The Hunterian Lectures
ON
INFANTILE SYPHILIS.

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LECTURE II.[1]

MR. PRESIDENT AND GENTLEMEN,—In my last lecture I dealt with the parental sources of inherited syphilis. I now proceed to treat of the symptoms of the complaint in the infant. These symptoms are so numerous and varied and affect so many parts of the body, either separately or simultaneously, that any elaborate treatment of any single one of them is incompatible with the time at my disposal. In fact, I feel now that instead of attempting to deal with such a controversial subject as infantile syphilis in its entirety it would have been better to have restricted myself to a more thorough consideration of a selected number of the chief manifestations of the complaint. Even as it is I must pass over many parts of the subject, not on account of their lacking either consequence or clinical interest, but because time will not allow me to deal with them in a manner at all commensurate with their importance. Some others of the less debatable points I also ignore, lest I incur the charge of "demonstrating the obvious and expatiating on the commonplace."

That the symptoms of inherited syphilis may be apparent in the dead-born fœtus or in the living child at birth must now, I think, be conceded by all. The word of obstetricians, who are the only persons with any great opportunities of experience on these points, is unanimous in this respect. It is true that such symptoms as maceration of the fœtus and the like—a necessary consequence of its retention *in utero* after death—were formerly too often and falsely ascribed to syphilis. The proof that such symptoms were not necessarily dependent upon syphilis, however, in nowise detracts from the testimony of the better informed, who have found uncontrovertible evidences of syphilis in the viscera, bones, and other organs of still-born infants. It is unnecessary, however, to dwell upon such cases; equally unnecessary, too, is it, I consider, to linger on the cases of infants presenting signs of unmistakable syphilis at birth. Such infants, in the vast majority of instances, are only foredoomed to die after the briefest span of life, even under the most skilful treatment and care. If recovery has taken place in infants presenting unequivocal signs of syphilis at birth, such recoveries are so exceedingly exceptional that any lengthy discussion on them would be unprofitable at the present place and time.

I have just said that infants born with unmistakable signs of syphilis speedily die. So short is their existence that few, if any, find their way to children's hospitals and kindred institutions. There is, however, one symptom of syphilis often present or commencing at birth that may appropriately be dealt with now. This is the marasmus or wasting that forms such a prominent feature in many cases of inherited syphilis. Now marasmus in a new-born child is far from being a certain proof that such a child is syphilitic. More than this, as a rule it does not manifest itself in syphilitic infants before other symptoms have cleared up the diagnosis, and in many syphilitic infants marasmus may never supervene. But still wasting may be the earliest symptom of inherited syphilis in the infant. I have known numerous infants brought to me at the East London Hospital for Children for wasting dating from birth develop other unmistakable evidences of syphilis whilst under observation. These infants have almost invariably died. Other marasmic infants whom I fancied were syphilitic have died before unequivocal signs of syphilis had possibly had time to develop. With these facts before my eyes I have on numerous occasions placed infants in whom wasting was the only objective sign on a course of mercury where the family history was suggestive of syphilis. This treatment has, I think, been attended in some cases with success, although the measure of success is not a great one. Some of these infants both gained flesh and developed syphilitic manifestations under the mercurial treatment. Others, whilst improving under mercury, developed no further syphilitic symptoms, owing possibly, I thought, to their abeyance under treatment. But early marasmus in syphilitic infants is of such grave import that treatment, let this be as early as it may, can claim but few successes.

The marasmus I have just mentioned is that present at birth or commencing soon after it. Such cases form but a small minority of those where marasmus plays a prominent part in inherited syphilis. Most syphilitic infants are plump and well nourished at birth and usually exhibit no trace of their complaint until a month or so later; then marasmus is apt to develop simultaneously with snuffles and rash. These last may disappear under mercury, but the marasmus is prone to persist and death may result from it at a period when all the more characteristic symptoms of syphilis have passed away. In other cases of undoubted syphilis a fatal marasmus may delay its appearance until months after that of the specific symptoms proper. It is in hand-fed infants, however, that marasmus has its most frequent and pronounced occurrence. Breast-fed infants, if specifically treated, usually escape it. It is only in such marasmic infants, I am inclined to agree with Henoch, that the peculiar *café-au-lait* tint of skin appears which Trousseau described as characteristic of cases of inherited syphilis in general. With Henoch and some other writers, too, I am at one in regarding marasmus as the most important factor in prognosis in the complaint. Other points that have been laid stress upon by some authorities, such as the early appearance, amount, and character of the eruption, the extent of the involvement of the viscera in the complaint, are, in my opinion, but seldom of the same prognostic significance as wasting. Henoch practically sums up the question of prognosis with the assertion that wasting infants die but well-nourished ones recover. Many wasting syphilitic infants, if they do not actually die from an obstinate and progressive asthenia, are very apt to do so from some intercurrent disease, such as collapse of the lung or diarrhœa, which they might have escaped or recovered from had they possessed greater vitality.

Thus far, except when it was present at birth, I have only treated of marasmus in connexion with syphilis in cases where the diagnosis of the latter was confirmed by the more unequivocal symptoms of the complaint. Cases where these last can be adduced in confirmation, however, in my opinion are far from being the only ones where an association between infantile syphilis and wasting can be traced. I have seen numerous infants in whom the only objective sign has been an obstinate wasting, and where the family history alone has been inferential of syphilis. Such cases occur in infants of any age, from that of three or four months upwards. The question arises as to how far it is justifiable to regard such cases of wasting as syphilitic where there are no direct evidences of that complaint beyond, possibly, the family history. The majority of authorities would, I believe, protest against such an assumption as unjustifiable from the absence of the more characteristic symptoms and as unduly and unnecessarily extending the domains of syphilis to unknown limits. Accordingly, whilst in most descriptions of inherited syphilis wasting is mentioned in connexion with other symptoms, it is in but few that it is treated as possibly the only manifestation of the complaint. For my part I can see nothing unreasonable in the diagnosis of syphilis in many wasting infants in whom there is an entire absence of specific symptoms, and in this contention I am happy in being supported by the majority of my colleagues. Snuffles and rash and other symptoms may be very evanescent, occasionally missed, and even when marked may disappear with doses of mercury totally inadequate for the cure of the complaint. Again, the first appearance of specific symptoms may not occur for many months later than the majority of text-books allow. Nowadays, moreover, we are even told that the manifestations of inherited syphilis may be retarded until puberty or many years later still. In numerous ways, then, it may well happen that one may be frequently called upon to treat a case of syphilis in an infant in whom the only noticeable symptom is obstinate wasting, and in

[1] Lecture I. was published in THE LANCET of April 11th, 1896.

whom there is a totally negative history as to more unequivocal manifestations both in the present and the past. Dr. Donkin is, as far as I know, the only writer who has deemed such cases worthy of separate description, and he has done it so graphically that I need not go over the ground again. These cases of syphilitic atrophy are peculiar, he considers, in that they are not attended by any noticeable amount of diarrhœa or vomiting, and I agree with him in this and in his estimation of them as a large and important class that has not received sufficient attention at the hands of the profession.

The result of specific treatment cannot be applied as any fair test as to the syphilitic nature of such cases. Syphilitic infants with atrophy generally die, whether such atrophy date from birth or many months later, and whether treated with mercury or not. In some few cases I think I have succeeded in checking the wasting by means of that drug. In one or two younger infants, moreover, the use of mercury seemed to bring out other and more certain signs of syphilis beyond the wasting. The improvement in nutrition produced by the drug appeared to allow the production of these other syphilitic symptoms in infants previously too reduced in vitality for their manifestation, but their appearance with the administration of mercury may have been mere coincidence. The failure of mercury in infantile syphilis where atrophy is a prominent feature is readily accounted for by the post-mortem revelations in such cases. These show that the atrophy is by no means limited to the external parts under observation, but that it involves the internal organs at the same time. In many such cases the small intestine is found to be almost practically deprived of its mucous and muscular coats, being little more, in fact, than a semi-transparent tube of peritoneum. To a less degree the stomach and large intestine suffer from the same destructive change. With this atrophy of the secretive and absorptive surface of the intestinal tract it is evident that no satisfactory digestive processes could possibly take place. The liver, too, in many instances is found markedly fatty, and this probably assists in maintaining the failure of nutrition. The condition of intestine I have just alluded to is found in other cases of atrophy besides those arising from syphilis, but it is in these latter, I believe, that it finds its most frequent and pronounced appearance. Dr. Donkin alludes to it in his work on Children's Diseases, but I know of no satisfactory account of it in the leading pathological treatises. Here I may say that this is the only abnormal condition of intestine that I am personally acquainted with in inherited syphilis. At numerous necropsies I have seen nothing resembling the gummatous indurations of the mucous and muscular coats or of the condylomata and ulcerations occurring in Peyer's patches, described by Oser, Jürgens, and others. The atrophic condition I have mentioned is amply sufficient to account for the mortality in such cases. Mercury may be capable of combating the syphilitic diathesis accountable for the condition, but it cannot replace the wasted glandular intestinal structures on which nutrition depends.

In an apparently healthy infant, presenting as yet no signs of the parental disorder, I think it will be admitted that a mercurial course as a preventive or precautionary measure is inadvisable, if not unjustifiable. This being so, then the limit of time of possible onset of symptoms is no unimportant question, not only on account of relieving parental anxiety, but of releasing the infant from the stricter forms of medical supervision. A great diversity of opinion as to the limits of time in which initial symptoms are possible occurs amongst authorities. On two points, however, all observers are agreed, these being that in the majority of cases symptoms appear in the second month of life, and that their primary manifestation is exceptional after the third month has expired. All experience agrees on these points and statistics amply confirm them. Kassowitz, indeed, would seem to doubt whether the primary manifestation of symptoms is ever deferred beyond the third month. Dr. Radcliffe Crocker asserts that the initial symptoms are never delayed beyond the sixth month. Henoch writes: "After the second, or still more after the third month, it is rare for them to appear for the first time; and when they occur still later it is always doubtful whether it is not a case of recurrence or of direct transmission." With these last-named writers I cannot agree. I have not infrequently seen infants where snuffles and rash had primarily manifested themselves much later in the first year of life than the sixth month, and one or two where symptoms had been delayed until the second year. Of course, I may be told that such cases were those of a relapse, and that the first appearances of the complaint had been missed. Such an assertion is equally easy to make as hard to disprove. I would only say that in my experience relapses of the skin affection are somewhat rare in the later months of infancy, the common expressions of a relapse at such times being the presence of mucous tubercles or condylomata. If we may believe, moreover, in the reality of a "syphilis tarda," so commonly accepted now, then I can see no inherent improbability in the first manifestations of the complaint occurring at a much later infantile age than is usually taught. Dr. Donkin has already written to the same effect, and I gather that others are now inclined to extend the limit of time during which initial symptoms are possible to at least twelve months from birth.

The first obvious manifestation of inherited syphilis is usually the well-known snuffles. This generally precedes any affection of the skin, and in only a small minority of cases is the skin eruption simultaneous with, or anterior to, the snuffles. It is only in very exceptional instances, too, that the swelling of the nasal membrane causes distress and difficulty in sucking before the snuffling develops. Snuffles, which usually precedes all other symptoms, may also long outlast them. A few doses of mercury may cause the disappearance of all skin eruptions, but snuffles may persist for many months as the sole evidence of the complaint.

The prominence of snuffles in hereditary syphilis has often led, I fancy, to an erroneous diagnosis of that complaint from the presence of this one symptom alone. When it is marked and persistent in character I would admit a justification for the suspicion of syphilis in a large majority of cases in which it occurs. But the extreme sensitiveness of the nasal mucous membrane in infants leads to a minor degree of snuffling from many causes in cases where syphilis is out of the question. This sensitiveness of the nasal membrane persists for about the first year of life, and any undue exposure to cold may bring on a greater or slighter degree of snuffles in many infants. Its temporary character and the absence of other signs ought to be sufficient to dispel the suspicion of syphilis in the majority of such cases. There is, however, one complaint peculiar to infants where the presence of marked snuffling may mislead even the more wary. This is what Henoch has aptly named the "acute coryza of infants." In this an infant, generally after exposure to cold wind, is suddenly seized with high temperature and acute nasal obstruction, followed shortly, in most cases, by laryngitis or bronchitis. If seen for the first time towards the end of an attack, when all acute symptoms have subsided, the combination of hoarseness or voicelessness along with intense snuffling is very apt to lead to a confident, although erroneous, diagnosis of syphilis. The acute nature of the attack ought to prevent mistakes in anyone acquainted with Henoch's description of the complaint. In one case of this kind I knew dire offence given by an incautious catechising of the father which a short delay would have served to prevent.

The syphilitic affection of the nasal structures in infancy responsible for the snuffles generally leads to some broadening and depression of the root of the nose, more apparent, perhaps, than real. In most cases this is entirely recovered from, and the child grows up with a nose as well shapen as in those who are non-syphilitic. In a minority, however, a nasal deformity incurred in infancy persists throughout life. I have never in such cases noticed any undue fœtor in the nasal secretion suggestive of active bone destruction, nor have I ever learnt of the discharge of palpable portions of bone and cartilage which Diday and others write about. The explanation of the permanent nasal deformity incurred in infancy lies rather, I think, in changes occurring in the cartilage which interfere with its nutrition, and this defective nutrition is followed by arrested development. But beyond infancy there is no doubt that active destruction of the nasal bones can occur from inherited syphilis, and the usual time for this is generally from the age of four years to that of puberty. Not very infrequently, I believe, cases treated for strumous ozœna, with bone destruction, have their origin in inherited syphilis rather than struma, and I have known mercury and iodide successful in such cases where other measures have failed. In one interesting case I saw through the kindness of Dr. Julius Jacobson active nasal bone trouble occurred as late as the age of thirty-four years in a woman who was undoubtedly the subject of inherited syphilis.

The affection of the nasal membrane has little, if any,

tendency to spread to neighbouring parts, and in the early stages of infancy the pharynx generally appears perfectly normal. Diday dissents from this, as he states that repeated examinations only resulted in his finding insuperable difficulties in the way of pronouncing with any certainty as to the freedom of the pharynx in very young infants. At any rate, his repeated examinations did not enable him to find any frequent affection of the pharynx in such cases. What has been said as to the pharynx applies equally to the mouth in very young infants. Any shallow ulcerations of the mouth found in them are generally due to aphthous conditions, which are common enough in babies with no suspicion of syphilis. Henoch agrees with this, and gives useful warning against mistaking ulcers along the middle line of the palate in young infants for specific manifestations. Although in early infancy the mouth and throat are free, yet in infants some months old, whether with a relapse or not, the tonsils, fauces, palate, and buccal membranes may be the sites of a few scattered ulcers unmistakably specific in character. These affections of the mouth only occur in a minority of cases, and the infants in whom they appear are seldom less than four months old, and generally some months older than this. Fissuring of the lips, too, is a later symptom than some of the text-books allege. The infrequency of sores about the mouth and their late appearance in the disorder have, I believe, important bearings on the spread of the disease from infants to others.

Along with the sores in the mouth I have usually found mucous tubercles at the angles of the lips and often on other parts of the body where there is a combination of moisture and warmth. These mucous tubercles have been often described as one of the earliest symptoms of inherited syphilis, but this I am certain is a decided fallacy. Their real place is amongst the later signs that may occur in infancy. They are the commonest symptoms of all in relapses, and may recur from time to time, as the sole evidence of the disease, until the child is five or six years old. Henoch has pointed out the much greater luxuriance of the growth of mucous tubercles and condylomata in the acquired syphilis of children than in the inherited form, and in this my experience fully tallies. I have seen cauliflower masses of condylomata in acquired syphilis in children such as I have never seen approached in inherited cases. These mucous tubercles afford the surest evidence of syphilis where other signs are doubtful. I quite agree with Mr. Hutchinson that one well-formed mucous tubercle or condyloma is pathognomonic and an incontrovertible proof of the complaint.

The skin eruptions have been so frequently and fully dealt with by others more competent than myself that I feel any lengthy description of most of them uncalled for. My former colleague, Dr. Radcliffe Crocker, whose experience was largely gained from the same sources as my own, has indeed rendered any attempt in this direction superfluous on my part. All I would propose to do then is to take the arrangement and classification laid down in Dr. Crocker's treatise on Diseases of the Skin, and to briefly deal with the different eruptions with such comments as personal observation may seem to warrant. The most frequent sites of the eruption are admittedly the buttocks and adjacent parts, the chin and upper lip, the eyebrows, and the skin behind the ears. In exceptional and generally fatal instances the eruption may be universal over the body. Of the parts mentioned the buttocks and their neighbourhood are those most frequently affected, and very commonly, indeed, the only ones. I cannot recall a case where there was any very decided eruption where the buttocks remained free. These parts are usually also the first to show the eruption, and are the ones most deeply affected even when it is fully developed on numerous other places. Next in frequency to the buttocks as sites for the eruption come the upper lip and chin. It has been assumed that the reason for these situations being the commonest ones for the syphilitic eruption is that they are the ones most subject to irritation from contact with wet napkins and saliva or mucus. To this view I have never altogether assented. Some of the other parts commonly affected by the syphilitic eruption are subject to no irritation that would explain their prominence in this respect over others of the body. In the acquired syphilis of infants, moreover, the eruption shows no preference for the parts most affected in the inherited form, although the sources of irritation are the same in each. Other eruptions, too, confessedly owing their origin to some source of irritation, show no special preference for the sites most commonly affected in inherited syphilis. I cannot help thinking, then, that there is some selective influence at work beyond mere irritation that determines the eruption to its favourite sites, the reason of the selection lying deeper than our present knowledge can explain.

Syphilitic roseola, far and away the most common form of eruption in adult acquired syphilis, is extremely rare in the inherited disease. I have never seen an example of it in the latter. Cases are, however, related by Bassereau, Cullerier, Dr. Crocker, and others. The record of single cases by these last-named is sufficient testimony to the rarity they place upon it. Although I have never seen this form of eruption in inherited syphilis I have several times seen it in the acquired variety in both infants and elder children. When seen in these last it differs in no respect either in situation or appearance from that occurring in adults.

Although syphilitic roseola is extremely rare, another of the erythematous eruptions is the commonest of all in the inherited disease. The following account by Dr. Crocker so graphically describes it that I prefer to give it in his own words: "It consists of erythematous patches of various sizes which usually commence on the buttocks and round the anus. They may be well or ill-defined at the edge, bright coppery or yellowish red, tending to coalesce into large sheets of eruption, but generally patchy on the borders. This erythema may extend uniformly on the back and inner side of the legs quite down to the feet, including the soles, which are bright red and peeling. On the front and outer side it is still generally patchy, upwards it often extends to the loins and abdomen, and in a few cases all over the body in patches which coalesce; the whole surface is then red and desquamating on the dry parts, while on the buttocks or where it is exposed to moisture the scales are soaked off and the surface is left raw or brightly glistening. These generalised cases are very likely to die." As to the fatal nature of these cases with extensive erythema, my experience fully tallies with that of Dr. Crocker, and Henoch writes to the same effect. A papulo-squamous eruption corresponding to that of acquired syphilis is the next most common one in the inherited complaint. The following description, like the preceding one, is taken from the same source, the work of Dr. Crocker. "It consists of round superficial patches, from one eighth to half an inch in diameter, very slightly raised above the surface, delicately scaly, with a pink or reddish-brown colour at first, but after a few days of a pale fawn tint. It may be limited to one or more regions, such as the limbs, forehead, or round the mouth, or occupy the whole body surface, usually in discrete patches, and commencing upon the buttocks, where the superficial ulceration is apt to occur from the irritation of the urine and fæces. A variety of this is a crescentic squamous eruption with a raised border, which in one of my cases began on the buttocks a week after birth and then spread over the thighs and then all over the body, forming map-like outlines on the skin, most marked on the lower part of the body and legs."

Besides this last Dr. Crocker describes three small papular forms of eruption—the acuminate, convex, and flat. The first two may be crowned with a scaly cap, a small bead of pus, and less seldom with a clear vesicle. All these forms occupy the usual sites of the other eruptions, run the usual course, and are not significant of any particular import in prognosis or severity of the disease.

Vesicular eruptions are rare in inherited syphilis and are usually preceded by other forms of eruption. The skins of syphilitic infants, too, are more prone than those of others to respond to external irritation. In this way eczema and other inflammatory eruptions may break out in syphilitic infants independently of the constitutional complaint.

Pustular eruptions are much more common than the vesicular, but, like the last, are seldom the primary ones in the complaint. Any of the previously mentioned forms under continued irritation are liable to take on a pustular character. Besides these, however, others may be pustular from the onset. Thus ecthymatous sores are far from uncommon, covered with a greenish crust, concealing sharp-edged spreading ulcers or simple excoriations. They show no preference for any part of the body and are seldom numerous, but they generally denote a profound cachexia and are of bad prognosis.

One of the pustular forms is deserving of further notice. This was first described, I believe, by Dr. Barlow, and is known as the "syphilitic furuncle," although a more appropriate name could possibly be found for it. It is of importance as being often the sole manifestation of the later stages of

inherited syphilis, and its significance in this respect is, to my personal knowledge, only too often overlooked. In its typical form it consists of an elevation of the epidermis of the size of half a hazel nut, the raised epidermis being generally of a deep purple colour. There is very slight hardening of the surrounding and underlying skin, and under the purple epidermis is a scanty secretion of ill-formed pus. If left to itself it may persist for long without the skin giving way, but under mercurial treatment it rapidly disappears without scarring. Without treatment it is apt to leave a small nodular thickening in the subcutaneous tissue, with a corresponding slight depression in the overlying epidermis. The same small nodular thickening in the subcutaneous tissue may occasionally be found preliminary to the formation of the cutaneous pustule. These "syphilitic furuncles" are most common, perhaps, in children two or three years old and are rare before the eighth or ninth month. They may appear anywhere on the body, but are most frequent, in my experience, on the upper and outer aspects of the thighs. As an indication of syphilis, when other signs are wanting, I consider them of prime importance. On two occasions my diagnosis of syphilis from their appearance alone was confirmed by the discovery of unsuspected mucous tubercles. At one time I looked upon them as pathognomonic of syphilis, but in one case I came across "furuncles," undistinguishable from those described, where syphilis could with certainty be excluded. They indicate syphilis, however, in the majority of instances, and the non-recognition of their significance by many observers is matter for regret.

Bullous eruptions are more common in inherited than in acquired syphilis. Pemphigus is one of the best recognised forms of eruption in the former. It is usually either present at birth or commences a few days later, seldom later than the first week. Dr. Crocker, however, mentions a case where it first appeared in an infant a fortnight old. It is usually confined to the hands and feet, and here more especially attacks the palms and soles. The nail beds, too, are generally affected with destruction of the nails. The situation of the eruption, mainly the palms and soles, is sufficient to distinguish it from another infantile form of pemphigus, arising from bad hygienic surroundings which shows no preference for these sites. The bullæ, too, in the syphilitic variety are flaccid and contain pus or blood; in the other variety they contain clear serum. The almost fatal prognosis attaching to pemphigus in inherited syphilis is disputed by none, and I have never known a case recover. Pemphigus in the later stages of infancy is not uncommon, but when occurring then has no connexion with syphilis in particular.

Although gummata are not, of course, confined to the skin, yet they may appropriately be dealt with now, as completing what I have to say on the cutaneous eruptions. All observers are agreed as to the rarity of gummata in the skin in inherited syphilis. My personal experience is limited to perhaps half-a-dozen cases. In only two of these did they break down forming the well-known characteristic ulcers, and even in these two there was a doubt in the history as to whether the syphilis was inherited or acquired. In the others they persisted for a long time, in spite of treatment by iodide, and this increased resistance to that drug would seem, in my limited experience of them, one of the peculiar features of gummata in the inherited form of the disease. The youngest of my patients was about two and a half years old, and the rest several years older than this. What has been said as to the rarity of gummata in the skin applies equally to gummata elsewhere in the inherited complaint. The cases I have seen of older children with destructive lesions of the palate and adjacent parts are not more numerous than the ones where gummata occurred in the skin. In more than one of these, again, the history was doubtful, and I was uncertain whether the disease was inherited or acquired. Gummatous infiltrations of the skin are of interest as being, in the opinion of Dr. Crocker and others, the only skin eruption found in the latest stages of inherited syphilis. Of this nature are probably the lupus-like conditions described by Mr. Hutchinson as occurring along with interstitial keratitis and allied disorders. These later skin eruptions are certainly rare, but I have seen one or two examples of this syphilitic "lupus" in children near the age of puberty.

One peculiarity about all the skin eruptions in early infancy is the rapidity with which they disappear under treatment and the little tendency they have to recur provided this last have been at all adequate. Mr. Hutchinson writes: "If an infantile eruption due to inherited syphilis have once disappeared under treatment, it but seldom, in my experience, shows any tendency to recur. The relapses so frequently seen in adults who have acquired the disease find no place in infants." With this opinion of Mr. Hutchinson I agree, provided, as I have said, that the treatment be efficient. During the first year I should not consider it very uncommon for the skin eruptions to disappear and relapse where the treatment had been little or none. After the first year, however, eruptions of any kind, except mucous tubercles or condylomata, are exceedingly exceptional under any circumstances whatever.

One of the most marked characteristics of inherited syphilis, as compared with the acquired form, is the early and frequent involvement of the viscera in the former, leading to their enlargement. The recognition of the affections of the abdominal viscera in inherited syphilis is not of modern origin, many of the older writers being as fully cognisant of them as those of the present time. The viscera most affected are admittedly the liver and spleen. It is, indeed, in only a minority of cases in my experience that the latter is of normal size. In 100 cases of inherited syphilis under my care I found the spleen enlarged in 62, and in 19 others its size was probably above the normal. Dr. Gee, however, only found the spleen enlarged in 45 per cent. of his cases. The splenic enlargement generally dates from birth and may certainly exist before any other symptom has manifested itself. In 92 examinations of macerated syphilitic fœtuses Mewis, cited by Mr. Hutchinson, found the spleen enlarged in 72—i.e., about 78 per cent. The fact of its occurrence *in utero* accounts for the early enlargement of the spleen to be found in living infants. In some few cases I have found the spleen enlarged in later months where I was unable to do so in the earlier ones, so that I am not inclined to regard the affection as necessarily a congenital one. The enlargement of the spleen in inherited syphilis is, I should say, very rarely carried to any great extent. In uncomplicated syphilis I have never known the hypertrophy of the spleen so great, at least in the first year of life, as to suggest any connexion between it and an associated condition of blood change, although such a connexion has been described by others. But anæmia is so common in inherited syphilis—and, indeed, in infants generally of the age in question—that it can seldom be necessary to assume any causation for it in the splenic affection. The profound anæmia and changes in the blood and bones which are sometimes found along with splenic enlargement in syphilitic infants in their second year are, in my opinion, more fairly ascribable to rickets, which almost invariably complicates the former complaint at that period. It is only in exceptional instances, moreover, that the hypertrophy from syphilis persists beyond the first year.

As far as present knowledge attains there is nothing specific in the changes in the splenic tissues that lead to its hypertrophy. The resulting pathological condition is a simple hyperplasia of all the splenic elements, and there is nothing, microscopical or otherwise, serving to distinguish this hyperplasia from that occurring in rickets and other infantile disorders. There may be, perhaps, some greater tendency in the syphilitic affection for thickening of the capsule to accompany the other splenic changes. Any conditions allied to gummata I have never seen in the spleen in syphilis. It is true that in one or two post-mortem examinations in children I have seen scarring of the splenic surface, but this fact in no way necessarily implies the former existence of anything like gummata in the organ.

After the spleen the liver is the viscus most frequently affected. The difficulties attaching to the recognition of the slighter degrees of enlargement of the liver may possibly lead to an under-estimation of the frequency of its affection. Writers of the time of Diday would seem to have regarded it as of almost universal occurrence, the last-named, indeed, somewhat fancifully suggesting that induration of the liver in the inherited form corresponded to the primary chancre of acquired syphilis. Mewis, in the statistics before referred to, in 92 syphilitic fœtuses found the liver diseased in 52 instances. The frequency with which it is found in the dead fœtus would suggest its early occurrence in the living subject, and most cases of syphilitic affection of the liver, I believe, date from birth. The changes in the organ are those of an interstitial hepatitis. Along with the increase of the interlobular tissue there is a certain amount of atrophy of the cells with destruction of the blood-vessels and thickening of the capsule. The interstitial hepatitis, as a rule, affects the whole organ, but in some cases

certain lobes, or parts of them, entirely escape or are less affected than the rest. Even with extensive disease of the organ gummata of the liver are exceedingly rare, if not unknown, in infancy. In older children I have seen them post mortem, and in two cases have known them diagnosed during life with some degree of certainty. Considering what an important part the functions of the liver play in infancy it is reasonable to suppose that such a marked change in its structure as this interstitial hepatitis entails cannot be without serious detriment to the patient. The older writers, then, were possibly right in the importance they placed on the digestive disturbances arising from syphilitic liver disease in infants, and it may be that we do not sufficiently regard them. Marked enlargement of the liver and spleen is certainly an unfavourable factor in prognosis. But symptoms directly chargeable to the affection of the liver are extremely rare. A case recorded by Depasse is, as far as I know, the only one where ascites was clearly connected with syphilitic disease of the liver in an infant. Jaundice is much more frequent, but still a rarity considering how frequently the liver is diseased. Such jaundice, I believe, almost invariably dates from birth and is generally slight in amount, but if the bile vessels be involved in the liver changes may attain a high degree of intensity. Whether slight or intense, jaundice in infants arising from inherited syphilis is generally fatal. I have known several instances of it, all fatal, and Henoch records others where along with the jaundice he found hæmorrhage into the stomach from obstruction of the portal vein. Henoch, too, mentions the case of a syphilitic woman who bore three infants who all died soon after birth from congenital jaundice. As the effect of treatment, or independently of it, the enlargement of the liver disappears or largely diminishes during the first year of life. In some instances, however, the enlargement lasts for years. I have known two children eight or nine years old, with a clear history of inherited syphilis, in the East London Hospital for Children, in whom there was ascites with the enlargement of the liver, and where what were taken to be gummata in the latter could be felt through the abdominal wall. One case required repeated tapping, but both finally recovered under treatment with mercury and iodide.

Since Dubois first described a syphilitic affection of the thymus gland in 1850 many, if not most, writers have concurred with him in recognising a similar disease of that viscus in inherited syphilis. It is claimed by some that the thymus gland is the earliest of the viscera to be attacked and that it may even be the only one to show the syphilitic taint. Dubois described two varieties, or rather grades, of this syphilitic affection of the thymus. In the first the organ is but little, if at all, enlarged. On section it is found studded with cavities varying in size from that of a pin's head to that of a pea, from which a yellow, pus-like fluid exudes. In other cases no visible cavities are found, but the same fluid can be made to exude in drops by squeezing the gland. In the second class of cases the organ is considerably enlarged, and cavities as large as a walnut may be found containing the same yellow fluid as in the first class. This fluid, Diday states, had been carefully analysed, and was found to bear all the physical properties and microscopical tests of pus. Without at all wishing to deny a syphilitic affection of the thymus, I would beg to state that a further proof of its reality is needed than that furnished by Dubois and his successors. I have seen the condition of thymus described by Dubois in syphilitic infants, but more often in infants in whom there was no reason to suspect such complaint. In one infant who died from croupous pneumonia, and who had been perfectly healthy until the commencement of the fatal illness, I saw the thymus immensely enlarged and containing a cavity filled with about half an ounce of the yellow fluid. I have never analysed this fluid, but to me the naked-eye appearances of it are not identical with those of ordinary pus. Since preparations of the thymus, too, have found a therapeutic use I hear that the manufacturers have to reject a fairly large percentage of the glands supplied to them owing to the presence of these fluid-containing cavities. It is in cases of inherited syphilis, possibly, that necropsies on very young infants are most often performed and where special attention is paid to the state of the thymus. Were necropsies as regularly made on very young infants dying from other causes than syphilis, and equal attention paid in them to the state of the thymus, I have a suspicion that the cavities in question would be found as often in these cases as in the syphilitic ones. On these grounds, then, I feel justified in my belief that up to the present the involvement of the thymus in inherited syphilis is at least not proven.

What has been stated as to the thymus applies also to the pancreas. Many writers describe a syphilitic affection of this latter in the inherited forms of the complaint. As far as I can gather the chief reason for the belief in such an affection has been an unnatural hardness in the pancreas. Now I have seldom attended a necropsy on an infant a few months old without being struck with the much firmer consistence of the pancreas than that obtaining in the case of older children. It is, I believe, a physiological and not a pathological condition and due to the active developmental and functional changes taking place in the viscus in early infancy. Before assuming, then, the reality of a syphilitic affection of the pancreas I consider that further evidence is necessary beyond a mere increase in the consistency of the organ.

An Address

ON

THE NEXT GREAT ADVANCE IN ANÆSTHESIA; INCLUDING A NEW EXPOSITION OF COMMON SENSIBILITY.

Delivered before the Society of Anæsthetists on March 19th, 1896,

BY SIR BENJAMIN WARD RICHARDSON, M.D., F.R.C.P. LOND., F.R.S.

MR. PRESIDENT AND GENTLEMEN,—I remember no event in the course of this century that ever filled the public mind with greater wonder than did the discovery of anæsthesia fifty years ago. It was not altogether an unexpected discovery, for many men in the background of history, as we may say, had for ages been working at it; but the general mind had become primed with the idea that pain was a necessary part of creation; that it entered the scheme of nature as a necessity; and that to try to abolish it would be sure to be a failure. The first part of this objection was urged after the discovery of abolition of pain had become a successful fact, and the wonder, altogether, has not passed absolutely away even in the present hour. At this time, however, we are confronted with a new difficulty; we are hearing week by week about the deaths that are taking place through anæsthesia. At first the deaths were very few, and had it been otherwise, that is to say, had there been many deaths previous to that of Hannah Greener, which occurred at Winlaton, near Newcastle, on Jan. 28th, 1848, anæsthesia would probably have died out as a practical part of surgical science. As it happened, a rare death from it did not materially affect the process of anæsthesia, and it is not until now, when the process of administration has become all but universal, that we find the public, as well as the professional, mind becoming astonished and perplexed at reading of the frequency of the occurrence. I do not know that there are more deaths now amongst those who take chloroform than there were in the early days of which I have spoken, for I remember very well, at the time when Hannah Greener died, a practitioner named Mr. Robinson, who lived at Haverhill in Essex, telling me privately of a similar disaster that occurred to him in his own practice and that was never made public, the tendency in those days being less strong in the matter of publicity. As time passed away the tendency to publish such details as those noted above became more and more marked, so that in the time of Dr. Snow we had such a number of deaths collected that he was able to announce no fewer than fifty, a number which included all that he was himself acquainted with from administration, but which did not account for two deaths, which he himself saw, from amylene. Snow collected his facts about the year 1857, and I published them from his manuscript in the following year 1858, anæsthesia having been in use in England for a

period of about twelve years. It looks, therefore, as if we only recorded five chloroform deaths a year for ten years or a tenth part of those recorded in the year 1895.

A few years after the death of Snow I made a tour through England and collected facts of the deaths which had occurred in various parts. I visited hospitals in which not less than 17,000 administrations had occurred without a death, but as I went on the deaths continued to increase on my register, not depending, as far as I then understood, on the hospital, the operator, the patient, or the mode of administration, but on accumulation of numbers of cases, so that I was brought to the conclusion in the years 1865–66 that deaths ought to be reckoned as one in every 2500, a figure which has been very particularly relied upon since I calculated it out, and which, I take it, is very close to the truth up to that date. It is not extremely difficult to account for this figure, quite apart from its having been based originally upon recorded facts, for it seems that there is always in a community a certain number of persons who, from one cause or another, are ready to die under unfavourable circumstances. I have named this class of mankind the "morituri" because of this readiness to die, and I estimate that there never exists a collection of 3000 middle-aged people but that there is sure to be one who is possessed of some fatal tendency which might lead to the occurrence of death, so that the administration of anæsthetics does not necessarily modify or intensify the chances of death amongst them. This is satisfactory as far as it goes, but at the same time, as all are not "morituri," it does not do away with the necessity of inquiry as to why death appears in the proportion named from anæsthesia. Neither does it limit our investigations into a mode of killing pain that could not possibly at the same time kill the person who would have to be anæsthetised. Dr. E. Andrews, the Professor of Principles and Practice of Surgery in Chicago Medical College, summed up his observations in 1870 almost in similar figures as mine. He calculated the deaths from chloroform as one in 2723, but he added other figures. He said that the deaths from sulphuric ether were one in 23,204 administrations; from mixture of chloroform and ether one in 5588; from bichloride of methylene one in 7000; while to nitrous oxide he gave the credit of not one death in 75,000 administrations.

Without staying to enter into any analysis of these figures we are obliged, as practical men, to ask the reason why there should be any deaths at all from anæsthesia, in which question we shall include why there are so many deaths from one anæsthetic and so few from others. If it be true that there are no deaths in 75,000 administrations of nitrous oxide there can be no reason, whatever may be our theoretical generalisations, why there should be so many from other anæsthetics except there be some error either in the anæsthetic employed or in the mode of giving it. Some will argue that season, temperature, and all the meteorological conditions are favourable to death in the case of one anæsthetic and not in another; but this is hardly fair, because we calculate, or rather include, the same facts in one anæsthetic as we do in another, and we, therefore, ought to have the same results from one as from another. If I administer nitrous oxide as many times to 2500 different people and have no death, and administer chloroform to the same number of people and have one death, it is clear that, *ceteris paribus*, there is something in the nature of the anæsthetic that determines the result; or if I administer ether to 23,000 persons with one death, and administer chloroform the same number of times with more than nine deaths, which is about the estimate, it must turn out there is something in the composition of the two substances—ether and chloroform—which determines the result. It may be urged by other argumentatists that whilst there is a distinction between the composition of the two substances which yields such varying conclusions, a great deal has to be said in favour of the worst of them because of other virtues they possess. Thus the most fatal of the anæsthetics may have the virtue of being rapid in its action, convenient in its administration, and, while the patient is unconscious, certain in its effect. I have heard this urged ever since I can remember, and I recall, as if they were only at this moment spoken, the words of Snow himself to the effect that chloroform was to ether like the lucifer match to flint and steel; he preferred its readier application and accepted its risks. But this, I think, is not a good argument, for the reason that it only requires more industrious examination and consideration to obtain an agent which shall be just as safe as ether, or even as nitrous oxide, and yet shall possess all the qualities and characteristics in administration that chloroform possesses; that shall be as rapid as chloroform, as convenient, as certain, and, at the same time, as safe as any other.

This particular thought has been on my mind for half a century, and though I have not been able to solve the difficulties as I could have wished, they are what I would still like to press forward, and which I would rejoice to leave to the investigation and exposition of the future man who shall solve the problem. I perhaps cannot do better in this place and at this moment than point out what these difficulties are, and the mode in which I have laboured to overcome them, because in so doing I may lead someone else in the direction in which I have not had time to continue myself.

In promoting anæsthesia the thing we do is to make the person about to be anæsthetised imbibe and take into his blood and nervous system an atmosphere which shall so entirely change his whole nature that he shall go to sleep, and shall lose all that sensitiveness of his nervous system which, under ordinary circumstances, causes what is known as sensation, and in extreme circumstances produces what is called pain. A double or duplicate action is thus implied—one of sleep and one of insensibility. According to our present knowledge sleep and insensibility happen to be united, but there is no definite reason why there should be such unity. It is not absolutely necessary that there should be sleep, and impossible as it seems to be that a human body should have no consciousness of the surgeon's knife and yet be awake, there is no absolute reason why consciousness and insensibility should not be separated. We see, in fact, this phenomenon. I have known a person suffering from what is termed anæsthetic hysteria, who had no sensitiveness in any part of the skin, and who was yet able to carry on a conversation and to take food the same as if there was perfect sensitiveness. Moreover, I have had under my observation a patient suffering from partial paralysis, motory and sensory, who would not have suffered at all if the affected part of his body had been cut away, but who yet would have been conscious of all that was going on round about him. I have also met with some drugs which produce a partial insensibility and yet do not materially affect consciousness, and *vice versâ*. It is, therefore, not too much to expect that we may find agents which do really destroy sensibility without materially interfering with consciousness, and this is the direction in which we have to explore, a direction I have myself constantly been on the look-out for, but have never perfectly succeeded in completing. What the atmosphere is we want to introduce into the body which shall destroy sensibility, and, at the same time sustain consciousness, is the thing we have to look for, and we have also to consider what condition of the nervous system is induced which interferes with one function and does not interfere with the other, or *vice versâ*.

The first and most telling effect is that we can put the body in such a condition as absolutely to destroy all feeling and yet apparently not touch so as to injure those centres by which we think and act. This is precisely what we do under the influence of cold; we put a part of the body into such a condition that there shall apparently be nothing going on in it whatever in the way of chemical change; we freeze such a part and we say that it fails to receive those vibrations which we call sensory or sensational. We see a surgeon put a knife into such a part, and though we be the patient ourselves we do nothing but look on, nor do we from any local manifestation become aware of the most refined dissection or manipulation which the surgeon is effecting. When this is the fact it is certain that we are rendering benumbed or practically dead those parts of the nervous system which ordinarily are the seats of impressions which signify the person's sensibility, while there has been no injury to the other parts of the nervous system which convey to us intelligence of the vibrations leading to the manifestations of consciousness. This is a most singular circumstance, showing as clearly as can possibly be shown the duality of the animal system; the truth that duality can be distinctly separated, and that what we actually want to do is to find out how, through the whole system, to make such a duality and to let life, however low, continue in progress. In hibernating animals Nature, who is cleverer than we are, is apparently carrying on the very

process which I would define—that is to say, she is maintaining life without the necessary connexion of sensibility, for I have seen a hibernating animal which did not feel, and I suspect that hibernation will be the final triumph of anæsthesia. I have also seen an animal become insensible during the inhalation of oxygen condensed by cold, and if we could, by any fortunate method, discover a plan of making perfectly cold oxygen pass into the body the ends we have in view would for the time be completely attained.

While we wait for so grand an attainment we are bound to endeavour to produce a similar result by submitting the organisation to a series of gaseous or vaporous substances which, by their presence, shall have the power of performing the task that might come from mere cold.

NATURE OF COMMON SENSIBILITY.

I feel it will be best in this paper to place before the society the conclusions to which I have been led after a period longer than, perhaps, has been known to any other man and attended with more experimental research. I know that in what is about to be stated I am breaking completely away from the common dogmas of a physiological kind and am advancing entirely on new ground, but this I cannot help because I am merely following the facts that have been put before me by Nature herself in the course of my work. I hold, then, that we live obedient to the outer world, and that we live from the outer world and from nothing else, and are always picking up its vibrations as we do its food and drink. It is usually conceived that in the body the cerebro-spinal system is a kind of independent organisation and that all impressions are received by it and all commands are given forth from it; and this, no doubt, may be held in a certain way as the fact. But it is commonly assumed that the brain is fed by the blood and that upon such feeding it exercises its own independent functions. I do not myself accept this reading. I conceive that as we own nervous expansions like the retina, which seizes impressions from without by a very simple mechanism, so we have distributed over the whole surface of the body an impressionable nervous root or expansion which receives vibrations from all the universe; that enter us in the same way that the retina receives special impressions; that the nervous expanse distributed over us is made up of, and concentrated into, nervous fibres, and that nerves thus formed carry to the brain the impressions we have received just in the same way as the optic nerve carries the picture. Thus every vibration made upon the outer surface of our bodies—from the mere vibration incident to heat and cold, from the vibration incident to the merest touch, or the vibration incident to the surgeon's knife—are all gathered up by the nerves from the nervous expanse and so conveyed to the central organ of the nervous system. This universal expansion from which sensitive nerves spring is, in my opinion, everywhere in the body where blood can penetrate, where blood can burn, and where, by burning, animal heat is generated, and can not only find its way in nerve tracts, but can also yield the substance out of which the tracts themselves are formed. That the natural brain or mass of nervous matter so carefully sealed up can receive all the impressions given to it, and, receiving such, make the body the companion and—it may be said—a part of all the universe, is a clear and simple proposition. It is not strange that centres which can thus receive impressions can lie by and give them out in their turn—acts that the nervous system performs, taking in whatever vibration is presented to the nervous expansion by which it receives sensation, and giving back that with which it is surcharged in the form of motion. The explanation given tells with special effect in regard to anæsthesia because it conveys that whenever through the blood current we diffuse over the whole nervous expanse, in which vibrations arise, some substance possessing the power of modifying natural vibration, we, by necessity, get an effect. To my mind, therefore, when with the air in the blood we spread, to every part of the body the air can reach, a foreign substance like chloroform or any of its allies, we so modify vibration that the sense is lost to the full extent of the diffusion of the substance we have introduced.

In the course of my life I have tested the effects of over thirty-five different substances which are capable of passing by diffusion with the blood over the universal nervous surface, and I have divided these substances according to their nature, or rather according to their constitution. Starting with what I have considered an anæsthetic base, or basic element, I have followed the action of each substance and placed it under what seemed to be its true head; thus, taking carbon as a base, I have followed it through the amyl, the butyl, the benzine, the true carbon, the ethyl and ethene series, the methyl and methene series, and the turpene series. I have also, taking nitrogen and hydrogen as bases, followed the series apparently depending upon it, and by this increase have learned so truly the nature of results that, if the chemist can place before me any substance he may possess, telling me its composition, weight, solubility in water, vapour density, and boiling point, I can on pure grounds of calculation tell whether it is or is not an anæsthetic, and if it is an anæsthetic how much, according to the weight of the animal, it will take to produce narcotism; how long it would take in a given quantity, and what would be the termination of the phenomena before it escaped from the organism. I need not trouble the society with the details of these researches, but I may indicate that they have been repeatedly stated in the various papers I have read at different times; but what I would say is that no group of phenomena has ever occurred to me that has not to some degree resembled the effects arising from cold—that model anæsthetic which has already been referred to, and which seems to prevent the nervous expansion, either locally or generally, from absorbing and transmitting to the nervous fibres, which spring from it, vibrations of sensibility.

From these observations I am led to infer that anæsthesia whether local or general depends always upon the same condition, namely, the suppression of vibrations from the origins, or expansion, of the peripheral nervous fibres spread out in the membranous structures; nerves—according to my interpretation—commencing there, not terminating, and forming afterwards the nervous cords that pass and carry direct vibrations to the brain.

It seems to me also that there is a special arrangement for the commencement of the vibration, as in the act of vision, where the picture is directly imposed upon a special surface like the retina. Again, as in the case of hearing, the impression is made upon a vibratory membrane and is thus communicated to a nervous surface. Again, in regard to smell, the membrane is a nervous surface, the Schneiderian, and the impression is conveyed by special nerves rising from it; but the sensation we call feeling, which, indeed, is a sense as certainly as is seeing and smelling, is that common sensibility which springs from the vibration in the extreme termination of nerves in all parts; the vibratory movement which usually excites it being the oxidation which is taking place at every point between the oxygen of the blood and the structures it laves, a vibration easily communicable to all parts and easily transmissible from all parts to the centre through the nerves which originate in the periphery, to be reflected back again in the centre, when it is necessary, in the form of motion.

Under these observations we must consider every anæsthetic the same in action; if we freeze a part we stop peripheral vibration; if we abstract all the blood from a part we stop peripheral vibration; if we make extreme pressure we stop peripheral vibration; if we introduce some other agent locally we stop peripheral vibration; if we divide the filaments of nerves which conduct vibration we do the same thing; and, to crown the whole, if we introduce into the blood by the lungs some vaporous substance which the blood can absorb, and get that vaporous substance carried into the peripheral surface, we stop vibration everywhere and create universal anæsthesia. This propositon brings us direct to the agents which, being absorbed by the blood and carried by it over the whole system, interfere with the animal fire and suppress the vibratory origin of feeling—creating anæsthesia. It is this I have ever had in mind in considering what a true anæsthetic should be. Nitrous oxide is for a moment an anæsthetic simply, because it replaces oxygen and does not sustain universal vibration—is, in fact, an asphyxiated substance. Carbonic acid holds precisely a similar place. Ether stands practically in the same position, but with the difference that a little oxygen travels with it, so that vibratory phenomena are reduced rather than checked, and in the long list of anæsthetics which have passed through my hands I have seen not one the quality of which cannot be read off in a similar manner. Turning to chloroform, which we may still consider the king of anæsthetics, though it may be the most fatal, its action admits of ready explanation. It is quite certain to those of us who remember its origin that it came in first as an ether—the so-called "chloric ether." It did not come

from any theory as to mode of action, but simply from observation of effects; as a vapour it has the power of being slightly absorbed by blood; the blood does not take up a great deal of it, the whole mass of blood being able to absorb not more than 20 grains of chloroform so as to make a uniform diffusion. If more than this be introduced into the blood the chloroform begins to separate; its molecules begin to attract one another and form minute points or blocks, which refuse to make the complete round of the circulation, and which I have actually found in the blood as direct modifiers of its course through the minutest vessels. But when it is simply homogeneously diffused through blood itself, its properties are those of suppressing heat and interfering with the vibration which springs from the chemical change in progress. The way in which chloroform acts in this particular is, I think, not difficult to explain, and is due to one of its elements which is too heavy for the quick vibration which constitutes feeling; that element is chlorine, which forms a large part of the fluid, which is as 32 to 12 compared with the carbon, and 32 to 1 compared with hydrogen in the same quantity of fluid. No wonder, therefore, that it stops sensation and that in its presence the surgeon's knife or the burning cautery are not detected.

I have at all times seen that the chlorine has been the danger in regard to chloroform, and I once traced the direct action of chlorine in a specimen which I was administering to the subject. Fortunately, I saw this in time, and inhaling a little of the chlorine myself detected the cause of danger and did no further mischief. I have also observed that in tetrachloride of carbon, where the hydrogen is entirely removed, there were always signs of the influence of chlorine, and a great many years ago I was so impressed at these effects that I thought it would be possible to remove certain portions of the chlorine and to make a lighter compound. This led me to the employment of bichloride of methylene, which means a fluid from which one atom of the chlorine is extracted from the chloroform. The extraction is made by the action of zinc, which, in contact with chloroform, takes up a particle of the chlorine in the presence of a little alcohol, producing chloride of zinc and leaving a fluid containing a trace of alcohol with bichloride of methylene. In the first of these experiments I succeeded very remarkably, and from that time I have always administered methylene, instead of chloroform, with success. I treat with the silence it deserves the continental rumour that the great French chemist Regnault—who died on Jan. 19th, 1878—made a specimen of the bichloride, from which, in my opinion, the chlorine could not have been properly removed, and which was, therefore, fatal. I treat also with the same silence the widespread absurdity that bichloride of methylene is a mixture of chloroform and alcohol. At the same time I would never unduly press forward bichloride of methylene, first, because it is rather a difficult product to make, and, secondly, because it contains chlorine, which always has been, and is, a dangerous element. Chloride of methylene would, in fact, be a better compound to use than the bichloride, as it gets rid of two of the chlorine elements; but it is a gas, is managed with difficulty, and, again, it has the objection of containing chlorine. You will gather from these observations that the temporary introduction of a member of the chlorine series into the anæsthetic series has been from the first a mistake—a mistake which must by necessity be met in the future by the exclusion of so objectionable an element. What, then, you will say, ought to be put in its place? This is the grand question which is left to be solved. Many think that ether is sufficient; many do not think so, and it must of necessity be slower in its action because it contains oxygen. Bromine and iodine, which in many points play the part of chlorine, are objectionable on the same grounds, and all the amyl series, in which hydrogen is an important element, are objectionable because they are not easily soluble, but separate in the blood, and producing minute globules of themselves are obstructive to the course of the blood, and though I have tried them all, as well as the hydrides and olefiant gas—which is a pure hydro-carbon—I have found one or other objection against their use.

The body that has seemed to me to present the best qualities for general anæsthesia is what is called methylic ether, a substance on which I have reported several times and have administered over thirty times in surgical operations. It is an objection that it is a gas. I discovered it in 1867, and I repeat what I then said—namely, that it may be considered the safest anæsthetic that has yet been discovered, although it is troublesome to administer and would have to be condensed like laughing-gas if it were to be brought into use. It has a curious faculty of destroying sensibility before it destroys consciousness, and recovery from it is exceedingly rapid. Its effects were very well manifested in a patient to whom I once administered the gas for Mr. Brudenell Carter. The patient, though feeling nothing, was quite conscious of all that went on during the operation. I observed also—and reported—that the gas is so safe that an animal under its influence may remain breathing it for twelve minutes without dying, and, if allowed apparently to die, may be recovered by artificial respiration so long as seven minutes after the cessation of respiration—that is to say, after what appears to be actual death.

CONSCIOUSNESS AND COMMON SENSATION.

It is time now that I concluded this paper and I do not think I can do so at any better point. Thirty years ago I showed that it was quite possible to destroy common sensation and yet not destroy consciousness, and I press this matter once again as of vital importance. In several cases where I administered the methylic ether for removing pain in surgical operations the patients, when quite insensible to pain, were so conscious that they were able to obey every request asked of them, and in some instances were even anxious to reason, stating that they knew what was going on, and arguing that they were not ready for the operation because they were sure they should feel pain. Nevertheless, in this state of mental activity they were operated upon, and afterwards, while remembering every incident, were firm in their assertion that they felt no pain whatever during the operation. One patient who sat for the extraction of two teeth selected the tooth to be first extracted, putting her finger to it, and afterwards rearranging her position for the second removal. To the looker-on it seemed, in fact, as though no change in her life had occurred, yet she affirmed that she was sensible of no pain whatever; and several other less striking, but hardly less singular, examples came before me. We may then, I think, fairly assume that in course of time we shall discover manageable and certain anæsthetic substances which will paralyse sensation only, leaving the muscular power unaltered and the mental little disturbed; and we gather from this either that in the cerebral hemisphere there is some distinct and simple centre of common sensation which may be acted upon by certain agents without involving all the cerebral mass, or that the peripheral nervous matter may be influenced without involving the other portions of the nervous system. On the whole I incline to the view that the action of those agents which destroy pain before they remove consciousness, is primarily on the peripheral system; for we know from the process of local anæsthesia that it is easy to destroy sensation at the extremities without destroying or even interfering with consciousness, while those who have inhaled the vapours which destroy common sensation before interfering with consciousness describe the experience of a numbness and insensibility in the extreme parts of the body.

That which we medical men most require is an agent that shall be easily applied, and shall admit of being so applied generally as to induce insensibility to pain with or without destruction of consciousness, as the case before us may demand. There are many minor surgical operations for which consciousness need not be destroyed, although pain ought to be; there are other operations in which the consciousness of the person operated upon is of great service to the operator; and there is a third class of cases in which it is essential to suspend both sensation and consciousness. Now those agents which first destroy common sensation can always be pushed to the extent of destroying consciousness, so that if we could get a perfect agent of the kind we should have the full requirements in our hand. Up to the present moment we have been content with two classes of agents, one which destroys consciousness and sensation at the same time; the other which locally destroys sensation and has no further influence. I look hopefully for a method in which, by means of a single agent, we shall be able at will to suspend common sensation alone, or to exalt the process into suspension of consciousness. When this object is attained with safety and facility the science of anæsthesia may be considered as perfected.

Postscript.

As I peruse the above MS. on this day, March 18th, 1896, I recall with great regret that the fatality from the administration of chloroform does not show any signs of decrease,

and that the patients in whom the deaths occur are, as heretofore, often sufferers from trifling ailments. I also notice that the symptoms of deaths are very rapid; that the amounts of chloroform administered are exceedingly varied, and that the mode of death seems usually to be the same as that in which Hannah Greener—who was the first to succumb to chloroform—died, some fifty years ago. I observe, further, that in one of the deaths from chloroform, which took place at Dudley, the patient was a healthy young man who submitted himself to the narcotic for the operation of tooth extraction; that he was fully examined beforehand and gave no indications of disease; that he inhaled with readiness; that the operation was performed dexterously; that the chloroform was perfectly pure; and that the post-mortem appearances afforded no evidence of the cause of the collapse. These frequent recurrences of death support the conclusions already advanced as to the danger attendant upon the reception of all bodies of the chlorine series, and they also suggest that every specimen of that series should be administered slowly in small quantities, so that narcotism should be induced by eighteen to twenty minims at the most. The question of small and slow administrations is one of the most critical, and makes a distinction between surgery proper and anæsthesia, which is of vital importance. When there was no anæsthesia, surgical art was, of necessity, predominant. The surgeon was the most brilliant man who could operate most quickly, and, with a steady nerve, could perform any possible operation. As a result of the work of ages it became natural that surgery should still in our days hold the first place, and that although in nineteen cases out of twenty the surgical operations might be mere bagatelles as compared with the production of unconsciousness by a narcotic agent, it has required a long time and a hecatomb of deaths for the fact to be demonstrated that the work of the anæsthetist calls for the first and most serious consideration. The old conception has continued to keep surgery in its original state and to cause anæsthesia to be looked upon as a mere adjunct. There is another element of danger in respect to the question of time. As in surgery brevity was the primary process, it came to be expected, both by the public and by the profession, that brevity in anæsthesia ought to keep pace. Thus during an operation the surgeon expects the completest insensibility, and, not getting it, spurs on the anæsthetist to be as brief as he wishes to be himself—a direction which the administrator, by habit, is as willing to obey as if he were simply an adjunctive aid. In the future all this must be changed. The anæsthetist must know and feel that he must be left quite independent in producing painlessness, while the surgeon, however brilliant, must follow his lead and not think of operating until the patient has been pronounced by the administrator safe, senseless, and ready for the knife.

LITHOTRITY IN CASES OF STONE: SIMPLE AND COMPLICATED.

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LIKE most surgeons called upon to treat a large number of calculous patients I consider that Bigelow's operation has proved itself to be in expert hands capable of yielding the best results in all simple cases of stone in children and in adults. I do not intend, therefore, to enter into any discussion as to the relative values of the different operations practised for the relief of vesical calculus, but simply to record my experience of lithotrity, to describe a few modifications which I have found useful in its practice, and, finally, to consider how far it is capable of maintaining its superiority in the presence of the complications most frequently met with in cases of bladder stone. I have in the title of this paper divided cases into two categories—simple and complicated. By a simple case I mean a stone of moderate dimensions and hardness situated in the bladder cavity of an adult or adolescent patient whose urethra is of at least normal dimensions, and who is free from any other important disease either of the urinary or of the general system. By a stone of moderate dimensions and hardness I mean one not exceeding 50 grammes (about 2 oz.) in weight and capable of being crushed by a No. 12 or 14 lithotrite. By a urethra of normal dimensions I mean one which will take without strain a No. 12 or 14 catheter of the English scale. Other cases I consider to be complicated, and it is evident, therefore, that a large proportion of all stones met with enter into this category. The complications to which I propose to refer are those arising from: (1) the size of the stone and its hardness; (2) its position; (3) the incomplete development of infancy and childhood; (4) old age and its associated degenerations; (5) various pathological conditions of the urinary system; and (6) the general condition of the patient. My remarks are based on the records of 209 cases contained in the following tables.

Table I. contains every case of stone in the bladder that I have operated on since the beginning of 1892 up to No. 200 with two exceptions. The first case not included occurred in a boy admitted with typhus fever, during the progress of which he was attacked with retention of urine. On passing a catheter a stone was detected, and it was decided to operate in order to prevent the urinary retention and other symptoms of stone from aggravating his disease. The stone was small and the operation (lithotomy) very simple; but the boy succumbed three days later to the typhus fever. The second case not included died under chloroform from chloroform poisoning. I had performed a few stone operations before 1892, but unless there was some great peculiarity had kept neither notes nor stones. In the beginning of that year I took over the whole of the operations for stone in the Cairo Hospital and commenced my collection and my record. In composing the tables I have taken advantage of the principle of the magic square. Having classified the cases according to the various conditions usually considered important in stone operations, age and sex of the patient, nature of operation and its result, the size of the stone and its chemical composition, I have been able, by adopting this principle, to show the relation of each one of these conditions to each one of the others. Under the heading of age I have divided my patients into the three periods of youth, middle age, and old age, allotting thirty years to each of the first two periods. The usual tendency in modern classifications has been to divide cases into children and others, or in the case of one of our greatest operators into old men and others. My experience has been, as with other surgeons, that the older the patient the more dangerous the operation becomes, with the proviso, however, that the age of the patient does not depend solely on the number of years he has lived. The other headings require no special notice, but I would draw attention to the columns showing the composition of the stones. It is remarkable that in so small a collection there should be so many examples of the rarer constituents. The analyses are above suspicion, having been made by a first-class analytical chemist, who has examined every stone for every possible constituent. I think that the remarkable results are due to the accuracy of the examinations, many constituents being detected which a more superficial examiner might have missed. In any case the presence of two stones containing cystine, of one composed almost entirely of urostealith, and of one containing xanthine in such a small collection is not in accordance with the experience of other operators. It is difficult to determine what proportion of the above cases should come under the category of "simple," for the reason that my records are not accurate enough as to the condition of the urinary and other organs, and I cannot, therefore, say what proportion of the simple cases have been treated by each of the various forms of operation. It will be seen, however, that 141 of the patients have been treated by urethral lithotrity, with a total mortality of 3. In one of three fatal cases the patient was more than eighty years old and had a stone of nearly two ounces; in the second the patient's age was about fifty-five, and his condition was complicated by fœtid cystitis in a very sacculated bladder; while the third patient was thirty-five years old and the subject of advanced kidney disease.

In performing lithotrity I have always carried out the method recommended by Bigelow—viz., complete evacuation of the stone at a single sitting. The patient has been in all cases prepared by one day's milk diet followed by a brisk purge. The operation has always been performed under chloroform narcosis. It is quite needless for me to describe in any way the technique of this operation, which has been brought to great perfection in many parts of the world, and more especially at the hands of some of our Indian surgeons. I doubt whether any other method will or can ever give in

TABLE I.—ANALYSIS OF 200 CASES OF STONE.

—	—	Total.	Age. 0-29	Age. 30-59	Age. 60+	Sex. Male.	Sex. Female.	Result. Cured.	Result. Died.	Nature of operation. Lateral lithotomy.	Nature of operation. Supra-pubic lithotomy.	Nature of operation. Lithotrity.	Nature of operation. Perineal lithotrity.	Nature of operation. Laparotomy.	Nature of operation. Others.	Weight of stone in grammes. 0-24	25-49	50-74	75-99	100-149	150-199	200-299	300+	Composition of stone. Oxalates.	Oxalates and Phosphates.	Urates.	Urates and Phosphates.	Oxalates and Urates.	Oxalates, Urates, and Phosphates.	Phosphate of lime.	Mixed phosphates.	Cystine.	Urostealith.	Xanthine.
—	Total.	200	67	113	20	198	2	190	10	28	6	141	21	3	1	118	49	12	11	3	5	1	1	13	16	20	68	16	14	3	46	2	1	1
Age	0-29	67	67	—	—	65	2	67	—	18	1	37	11	—	—	40	15	4	5	—	3	—	—	4	2	9	24	7	2	—	17	2	—	—
	30-59	113	—	113	—	113	—	106	7	8	5	90	8	1	1	66	29	7	6	3	1	1	—	8	13	7	36	9	11	3	24	—	1	1
	60+	20	—	—	20	20	—	17	3	2	—	14	2	2	—	12	5	1	—	—	1	—	1	1	1	4	8	—	1	—	5	—	—	—
Sex	Male	198	65	113	20	198	—	188	10	27	6	140	20	3	1	116	49	12	11	3	5	1	1	13	16	20	68	16	14	3	44	2	1	1
	Female	2	2	—	—	—	2	2	—	1	—	1	—	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—
Result	Cured	190	67	106	17	188	2	190	—	23	3	138	20	1	—	117	45	12	10	3	5	—	1	12	16	20	63	16	14	3	42	2	1	1
	Died	10	—	7	3	10	—	—	10	—	3	3	1	2	1	1	4	—	1	1	2	1	—	1	—	—	5	—	—	—	4	—	—	—
Operation	Lateral	28	18	8	2	27	1	28	—	28	—	—	—	—	—	25	3	—	—	—	—	—	—	2	3	5	8	2	—	—	7	1	—	—
	Suprapubic	6	1	5	—	6	—	3	3	—	6	—	—	—	—	1	1	—	2	1	1	—	—	—	—	3	1	—	—	—	2	—	—	—
	Lithotrity	141	37	90	14	140	1	138	3	—	—	141	—	—	—	89	41	9	2	—	—	—	—	10	10	11	52	10	11	3	31	1	1	1
	Perineal	21	11	8	2	21	—	20	1	—	—	—	21	—	—	3	4	3	6	2	3	—	—	1	2	1	5	4	3	—	5	—	—	—
	Laparotomy	3	—	1	2	3	—	1	2	—	—	—	—	3	—	—	—	—	—	—	1	1	1	—	1	—	1	—	—	—	1	—	—	—
	Other	1	—	—	1	1	—	—	1	—	—	—	—	—	1	—	—	—	1	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—
Weight in grammes	0-24	118	40	66	12	115	2	116	1	25	1	89	3	—	—	118	—	—	—	—	—	—	—	12	9	14	40	8	9	1	21	2	1	1
	25-49	49	15	29	5	49	—	45	4	3	1	41	4	—	—	—	49	—	—	—	—	—	—	1	3	1	17	3	4	2	18	—	—	—
	50-74	12	4	7	1	12	—	12	—	—	—	9	3	—	—	—	—	12	—	—	—	—	—	—	—	1	5	2	—	—	4	—	—	—
	75-99	11	5	6	—	11	—	11	1	—	2	2	6	—	1	—	—	—	11	—	—	—	—	—	1	4	3	1	1	—	1	—	—	—
	100-149	3	—	3	—	3	—	2	1	—	1	—	2	—	—	—	—	—	—	3	—	—	—	—	1	—	1	1	—	—	—	—	—	—
	150-199	5	3	1	1	5	—	3	2	—	1	—	3	1	—	—	—	—	—	—	5	—	—	—	1	—	2	1	—	1	—	—	—	—
	200-300	1	—	1	—	1	—	—	1	—	—	—	—	1	—	—	—	—	—	—	—	1	—	—	1	—	—	—	—	—	1	—	—	—
	300+	1	—	—	1	1	—	1	—	—	—	—	—	1	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—
Nature	Oxalates	13	4	8	1	13	—	12	1	2	—	10	1	—	—	12	1	—	—	—	—	—	—	13	—	—	—	—	—	—	—	—	—	—
	Oxalates and phosphates	16	2	13	1	16	—	16	—	3	—	10	2	1	—	9	3	—	1	1	1	1	—	—	16	—	—	—	—	—	—	—	—	—
	Urates	20	9	7	4	20	—	20	—	5	3	11	1	—	—	14	1	1	4	—	—	—	—	—	—	20	—	—	—	—	—	—	—	—
	Urates and phosphates	68	24	36	8	68	—	63	5	8	1	52	5	1	1	40	17	5	3	1	2	—	—	—	—	—	68	—	—	—	—	—	—	—
	Oxalates and urates	16	7	9	—	16	—	16	—	2	—	10	4	—	—	8	3	2	1	1	1	—	—	—	—	—	—	16	—	—	—	—	—	—
	Oxalates, urates, and phosphates	14	2	11	1	14	—	14	—	—	—	11	3	—	—	9	4	—	1	—	—	—	—	—	—	—	—	—	14	—	—	—	—	—
	Phosphate of lime	3	—	3	—	3	—	3	—	—	—	3	—	—	—	1	2	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—	—	—
	Mixed phosphates	46	17	24	5	44	2	42	4	7	2	31	5	1	—	21	18	4	1	—	1	—	1	—	—	—	—	—	—	—	43	—	—	—
	Cystine	2	2	—	—	2	—	2	—	1	—	1	—	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—
	Urostealith	1	—	1	—	1	—	1	—	—	—	1	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—
	Xanthine	1	—	1	—	1	—	1	—	—	—	1	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1

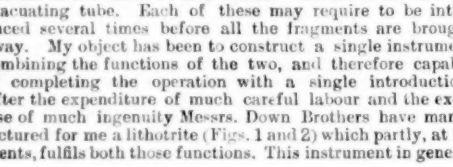
TABLE II.—ANALYSIS OF STONES PURCHASED FROM [illegible]

TABLE II.—ANALYSIS OF STONES WEIGHING FIFTY GRAMMES AND OVER.

—	—	Total.	Age. 0-29	Age. 30-59	Age. 60+	Sex. Male.	Sex. Female.	Result. Cured.	Result. Died.	Nature of operation. Lateral lithotomy.	Supra-pubic lithotomy.	Lithotomy.	Perineal lithotrity.	Laparotomy.	Others.	Weight of stone in grammes. 0-24	25-49	50-74	75-99	100-149	150-199	200-299	300 +	Composition of stone. Oxalates.	Oxalates and phosphates.	Urates.	Urates and phosphates.	Oxalates and urates.	Oxalates, urates, and phosphates.	Phosphate of lime.	Mixed phosphates.	Cystine.	Urostealith.
—	Total	50	17	28	5	50	—	42	8	—	11	15	20	3	1	—	—	19	13	8	6	1	3	2	4	12	15	6	1	—	10	—	—
Age	0-29	17	17	—	—	17	—	16	1	—	3	3	11	—	—	—	—	7	5	—	4	—	1	—	1	6	4	4	—	—	2	—	—
	30-59	28	—	28	—	28	—	23	5	—	7	11	8	1	1	—	—	11	8	6	1	1	1	2	3	5	9	2	1	—	6	—	—
	60 +	5	—	—	5	5	—	3	2	—	1	1	1	2	—	—	—	1	—	2	1	—	1	—	—	1	2	—	—	—	—	—	—
Sex	Male	50	17	28	5	50	—	42	8	—	11	15	20	3	1	—	—	19	13	8	6	1	3	2	4	12	15	6	1	—	10	—	—
	Female	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Result	Cured	42	16	23	3	42	—	42	—	—	6	15	20	1	—	—	—	19	12	5	4	—	2	2	3	11	11	6	1	—	8	—	—
	Died	8	1	5	2	8	—	—	8	—	5	—	—	2	1	—	—	—	1	3	2	1	1	—	1	1	4	—	—	—	2	—	—
Operation	Lateral	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	Supra-pubic	11	3	7	1	11	—	6	5	—	11	—	—	—	—	—	—	3	2	4	1	—	1	2	—	5	2	—	—	—	2	—	—
	Lithotrity	15	3	11	1	15	—	15	—	—	—	15	—	—	—	—	—	11	3	—	—	—	1	—	1	3	6	1	—	—	4	—	—
	Perineal	20	11	8	1	20	—	20	—	—	—	—	20	—	—	—	—	5	7	4	4	—	—	—	2	4	5	5	1	—	3	—	—
	Laparotomy	3	—	1	2	3	—	1	2	—	—	—	—	3	—	—	—	—	—	—	1	1	1	—	1	—	1	—	—	—	1	—	—
	Other	1	—	1	—	1	—	—	1	—	—	—	—	—	1	—	—	—	1	—	—	—	—	—	—	—	1	—	—	—	—	—	—
Weight in grammes	0-24	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	25-49	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	50-74	19	7	11	1	19	—	19	—	—	3	11	5	—	—	—	—	19	—	—	—	—	—	1	—	4	6	3	—	—	5	—	—
	75-99	13	5	8	—	13	—	12	1	—	2	3	7	—	1	—	—	—	13	—	—	—	—	—	1	5	4	1	1	—	1	—	—
	100-149	8	—	6	2	8	—	5	3	—	4	—	4	—	—	—	—	—	—	8	—	—	—	1	1	2	1	1	—	—	2	—	—
	150-199	6	4	1	1	6	—	4	2	—	1	—	4	1	—	—	—	—	—	—	6	—	—	—	1	1	2	1	—	—	1	—	—
	200-299	1	—	1	—	1	—	—	1	—	—	—	—	1	—	—	—	—	—	—	—	1	—	—	1	—	—	—	—	—	—	—	—
	300 +	3	1	1	1	3	—	2	1	—	1	1	—	1	—	—	—	—	—	—	—	—	3	—	—	—	2	—	—	—	1	—	—
Nature	Oxalates	2	—	2	—	2	—	2	—	—	2	—	—	—	—	—	—	1	—	1	—	—	—	2	—	—	—	—	—	—	—	—	—
	Oxalates and phosphates	4	1	3	—	4	—	3	1	—	—	1	2	1	—	—	—	—	1	1	1	1	—	—	4	—	—	—	—	—	—	—	—
	Urates	12	6	5	1	12	—	11	1	—	5	3	4	—	—	—	—	4	5	2	1	—	—	—	—	12	—	—	—	—	—	—	—
	Urates and phosphates	15	4	9	2	15	—	11	4	—	2	6	5	1	1	—	—	6	4	1	2	—	2	—	—	—	15	—	—	—	—	—	—
	Oxalates and urates	6	4	2	—	6	—	6	—	—	—	1	5	—	—	—	—	3	1	1	1	—	—	—	—	—	—	6	—	—	—	—	—
	Oxalates, urates, and phosphates	1	—	1	—	1	—	1	—	—	—	—	1	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	1	—	—	—	—
	Phosphates of lime	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	Mixed phosphates	10	2	6	2	10	—	8	2	—	2	4	3	1	—	—	—	5	1	2	1	—	1	—	—	—	—	—	—	—	10	—	—
	Cystine	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	Urostealith	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—

simple cases better results than this has given and it seems almost futile to attempt to modify it. I have, however, been induced to attempt a modification which, though unlikely to be attended by better results in simple cases, may be of service in a complication to be referred to later, and may, perhaps, recommend itself to the patient and surgeon from the simplicity and ease with which it may be carried out. Bigelow's operation necessitates the introduction into the bladder of two different instruments—the lithotrite and the evacuating tube. Each of these may require to be introduced several times before all the fragments are brought away. My object has been to construct a single instrument combining the functions of the two, and therefore capable of completing the operation with a single introduction. After the expenditure of much careful labour and the exercise of much ingenuity Messrs. Down Brothers have manufactured for me a lithotrite (Figs. 1 and 2) which partly, at all events, fulfils both those functions. This instrument in general

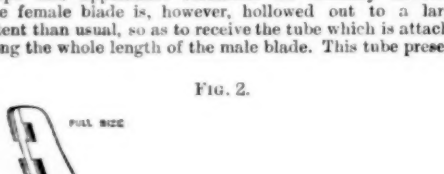
FIG. 1.



Distal end of lithotrite.

shape and appearance resembles an ordinary lithotrite. The female blade is, however, hollowed out to a larger extent than usual, so as to receive the tube which is attached along the whole length of the male blade. This tube presents

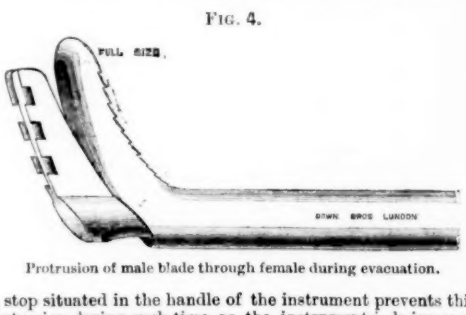
FIG. 2.



Distal end of male blade.

on its lower surface, just below the jaw of the male blade, a large opening, beyond which its end is filled up as in an aseptic catheter. The tube, continued through the centre of the screw, expands beyond the handle (Fig. 3) to receive the evacuating syringe. The male and female blades are so adjusted that when it is desired to aspirate the male jaw can be made to pass right through the female jaw, protruding to the extent of about four lines (Fig. 4) sufficiently to expose the eye of the male blade beyond the heel of the female.

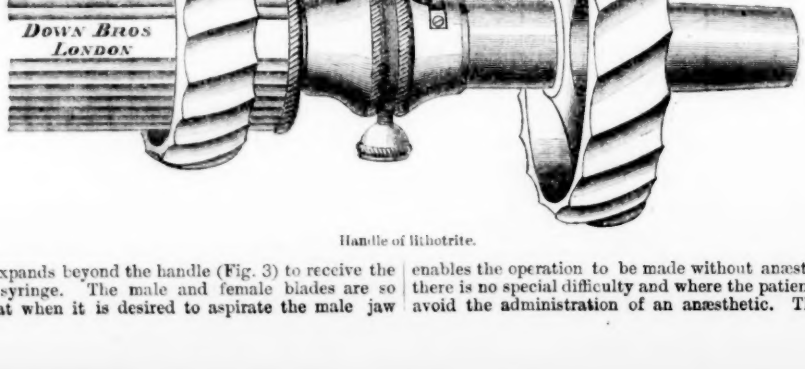
FIG. 4.



Protrusion of male blade through female during evacuation.

A stop situated in the handle of the instrument prevents this protrusion during such time as the instrument is being used for crushing. The reunion of the two functions of crusher and evacuator limits, as might be expected, the range of each. The instrument is of necessity weaker than an ordinary lithotrite of the same calibre. This has to a certain extent been remedied by the addition of a solid steel core, which, passing down the whole length of the tube, greatly adds to the strength of the instrument when crushing. This lithotrite is capable of crushing, and has crushed, a fairly hard calculus of 50 grammes; it must, however, always be used with great care and delicacy when dealing with such stones. The vast majority of stones, however, fall short of these dimensions and are such as to be quite readily crushed by this instrument. It is, moreover, chiefly in the case of old subjects that I think this method is likely to be most useful. When dealing with such cases it becomes of vital importance to treat the prostate as delicately as possible, and it is here that the great advantage of the single introduction will be found to lie. In these subjects, also, the stone, although apt to be large, is generally phosphatic in nature and friable, and under such circumstances the lithotrite is capable of dealing with quite large masses. As an evacuator, also, the instrument is less efficient than an evacuating tube of a similar gauge. The bore of the tube of a No. 14 evacuating lithotrite is equal only to that of a No. 11 or No. 12 catheter. The operation is necessarily, therefore, more prolonged, as the fragments must be broken up more finely. The instrument has, however, advantages which I think more than counterbalance these drawbacks. The single introduction which alone is necessary greatly diminishes the injury done to the urethra and prostate. In a healthy adult this has not the same importance as in an old man suffering from a large prostate. It is, however, especially in the latter class of cases that lithotrity becomes attended with danger, and it is in these cases that I think the modification is most likely to be of use. Secondly, it enables the operation to be made without anæsthesia where there is no special difficulty and where the patient prefers to avoid the administration of an anæsthetic. The operation

FIG. 3.



Handle of lithotrite.

without anæsthetics, however, requires very careful and very delicate manipulations, and should only be attempted when the patient objects to the narcosis or when there are other reasons against it. It must be limited further to cases in which the stone is small and easily friable. After the short experience I have had I would say that while advocating the evacuating lithotrite for use in the removal of small stones I can adduce no evidence to show its superiority in such cases to the ordinary instrument, and that I do not think it possible that its use will give any better results than those obtainable with Bigelow's method and instruments. The only advantage that I can see for it is in the possible diminution of the necessity for narcosis. I shall refer to the use of the instrument in complicated cases further on. I wish to say here a few words as to the evacuating syringe. I have used chiefly the syringes introduced by Thompson and by Golding-Bird. Of the two I consider the latter to be preferable; it is simple in construction, easily filled, and readily used. I have lately had made for me by Messrs. Down Brothers a syringe (Fig. 5) which possesses these advantages to a still greater extent. It consists of an indiarubber syringe shaped like a pear, with two stems, the one at right angles to the other. The horizontal stem carries a vulcanite socket to receive the evacuating tube. The vertical stem terminates in a glass receptacle for the débris. There are no valves and no taps,

FIG. 5.

Evacuating syringe.

the action of gravity alone being sufficient to prevent the return of the débris into the bladder cavity. The filling of this syringe is quite simple. The hole being held uppermost, water is poured in from the tap or jug. When three-quarters full the syringe must be slightly tilted to empty the glass receptacle of air. The removal of débris from the syringe is equally simple. The orifice should be closed with the thumb and the syringe inverted, so that, the glass receptacle being the highest part, the fragments fall into the ball cavity. The syringe is then turned so that the orifice becomes the lowest part, and the débris escapes with the water, one or two squeezes serving to expedite the escape. In addition to these advantages which it shares with other models this instrument possesses two peculiarly its own. In the first place, the mounts being of vulcanite, it can be easily sterilised. This point has not received, I think, sufficient consideration, and it is very easy to see that an infected syringe might have a very prejudicial effect on the result of an operation. Secondly, it enables the operator to have full control over the movements of the evacuating tube in the bladder. This is a point of very great importance, especially towards the close of an operation, and is not possessed by any of the more modern evacuators. It may further be added that it is greatly cheaper than any other form. The manipulation of the syringe when in use is very simple. The compression should always be gradual and but little water should be injected into the bladder. The expansion of the syringe should be sudden so that all fragments are easily lifted by the current. A very slight pause should be made before each compression of the syringe so as to allow the fragments to settle into the recipient. Having used this evacuator some sixty times I can confidently recommend it to other operators. In general I would say, therefore, with regard to simple cases of stone in the bladder that by far the best operation and the one which gives the best results is lithotrity at a single sitting, and that the use of an evacuating lithotrite may be useful in some cases.

With regard to complicated cases of stone, I have already mentioned the complications I propose to refer to and shall consider them in the order given. The first is that arising from the largeness and hardness of the stone. Table II. has been drawn up with reference to this complication and contains all the stones that I have operated on whose weight has reached 50 grammes. Thirty-two of these cases are taken from Table I.; nine of them were operated on before 1892. The specimens and records of these nine cases were preserved on account of the abnormal dimensions of the stones. Being selected cases they are not admissible in the general table, but the reason for their selection makes them specially suitable for Table II. The remaining nine form a portion of my third hundred, which is not yet completed. I have fixed the minimum weight for a large stone at 50 grammes, or a little less than two ounces. This limit is of course arbitrary. My reasons for choosing it are (1) it is numerically convenient; (2) few stones reach this size; (3) in all tables, old and new, the mortality attending operations on stones over this limit rises greatly; (4) I consider this to be about the limit at which a stone can be extracted from the wound of a perineal cystotomy in an adult without bruising or laceration of the tissues; and (5) it is about this limit that the difficulties of lithotrity begin. The arrangement of this table resembles that of Table I. and requires no further remark except with regard to the one operation classified as "other." This was a case in which the stone was lodged partly in the bladder and partly in the right ureter. It required for its removal a special operation, which is referred to later. Of the 50 cases here classified, 35 were operated on by lithotrity; of these not a single one died. When it is considered that in 8 of these cases the stone weighed between 2 and 3 ounces, in 10 between 3 and 4, in 8 between 4 and 8, and in one case over 12 ounces, it will, I think, be granted that no other operation has ever yielded such favourable results.[1] The cases have in no ways been picked and none have been refused operation. When I first began to operate I performed suprapubic cystotomy for nearly all large stones. Up to June, 1892, I had operated on 14 such cases, 11 by suprapubic cystotomy with 5 deaths, and 3 by lithotrity, all successful. Of the 36 similar cases operated since then, 32 were treated with lithotrity, 3 by laparotomy, and 1, complicated by stone in the ureter, required a special operation. The last 16 big stones have been removed by lithotrity and all successfully. I consider this result to be such a striking evidence in favour of lithotrity as a treatment for large stones that I have extracted the following small table of lithotrities from the general one.

TABLE III.—*Lithotrities performed for Large Stones.*

—		Total.	Age.			Weight in ounces.				
			0–29	30–59	60+	2–3	3·4	4·6	6·8	12
Lithotrity	Urethral ...	15	3	11	1	11	3	—	—	1
	Perineal ...	20	11	8	1	5	7	4	4	—

N.B.—All the 35 cases were cured without fistula.

It will be noted that in the tables above given the lithotrity cases are divided into two classes—urethral lithotrity and perineal lithotrity. By urethral lithotrity I mean Bigelow's operation; that is to say, the crushing of the stone and the removal of all the fragments at one sitting by instruments introduced through the entire urethra. By perineal lithotrity I mean the crushing of the stone by a lithoclast introduced into the bladder through a perineal incision and the removal of all the fragments through the same opening at one sitting. Bigelow's operation was performed in 15 of the 35 cases, and the more experience I have in this operation the more I am convinced that there are very few cases indeed which it cannot cope with. It is true that in the larger portion of the 35 cases I

[1] I have on another occasion (St. Thomas's Hospital Reports, London, 1891) referred to the extraordinary tolerance of Orientals to all operations and diseases connected with the urinary apparatus.

have performed the perineal operation. I have done so for one very sufficient reason. The operations are done before students and practically their only experience of stone operations is what they see me do. They will be called upon to operate on large stone cases, and for them and for the great majority of practitioners the perineal operation is by far the better. I therefore take frequent opportunities of demonstrating it to them. In the hands of a surgeon constantly operating, however, Bigelow's operation is practically capable of removing any stone however big. Very large stones have been successfully removed by it. Cunningham[2] records one of eight ounces, but even this has been surpassed by one of my recent cases, which I take the opportunity of recording here. The patient was an Egyptian fellah aged about forty-five years. The stone having been recognised as very big the largest lithotrite, having a gape of 5 inches (made to order for me by Messrs. Down Brothers), was introduced. After some difficulty the stone was grasped, the separation of the blades being to the extent of 4¾ inches. My whole force was necessary to crack the stone, and after a very tiring operation lasting 125 minutes the débris, amounting to 340 grammes, or over 12 ounces (dry weight), was entirely removed. The patient's convalescence was rapid and his cure complete. This is by far the largest stone I have ever crushed, and I believe it to be the biggest ever removed by Bigelow's operation. The stone was composed of urates and phosphates and was more than usually dense.

(To be continued.)

THE BRONCHITIS KETTLE, POULTICES, AND OVER-FEEDING IN ACUTE LUNG AFFECTIONS.

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IN these days of almost exclusive devotion to the study of micro-organisms and of abstruse chemical changes taking place in the body there is some fear lest the attention of the ordinary medical student should not be sufficiently concentrated on what, after all, is to be his main object in life—viz., the cure or alleviation of the maladies from which his patients are suffering. Dr. Church, in his recent Harveian Oration,[1] has pointed out in emphatic language that "the very brilliancy of recent discoveries and the vast increase in our knowledge may for a time react prejudicially on the art of medicine." I frequently hear complaints from the older practitioners with whom I come in contact that recently qualified men fresh from the hospital are almost useless as assistants; their theoretical knowledge may be excellent, but they are at a loss when they are confronted with the small details of general practice. May I, therefore, be allowed a little space in the columns of THE LANCET to discuss the prosaic questions of steam kettles, poultices, and diet! As a text for my sermon let me quote the treatment of a case of pneumonia as it is too often carried out—the unfortunate patient is kept in a room with the atmosphere saturated with moisture from a bronchitis kettle, enveloped in huge linseed meal poultices, and is given nourishment every half hour or so.

First of all as regards the practice of charging the air with moisture from what Sir Benjamin Richardson says is not inaptly called a "bronchitis kettle." The folly of this practice has recently been commented on in a monthly medical journal and attention was therein directed to Richardson's able article on "Hydrops Bronchialis" in the *Medical Press and Circular* of Jan. 25th, 1888. I am strongly of opinion that the bronchitis kettle should be practically banished from the sick room; the only instances in which benefit is likely to ensue from its use are cases of dry bronchitis, in which patients have difficulty in bringing up tough pellets of mucus, and even then I would not order it unless there was a dry easterly wind. In cases of pneumonia I have seen nothing but harm resulting from the employment of the bronchitis kettle, and I always advise that it should be taken away when I find it in use. I do not think that too great stress can be laid on the importance of a free supply of fresh air in cases of pneumonia, and this cannot usually be attained if the bronchitis kettle is at work.

The next point I would raise is as to the routine use of poultices. The longer I practise the fewer poultices I order, and at the present time I have come to the conclusion that except for the relief of pain poultices are of little or no value in the treatment of chest affections, or perhaps I might put it in another way—that the drawbacks inseparable from the use of poultices are not compensated for by the amount of benefit which can reasonably be expected to result from them. To watch a small child with extensive broncho-pneumonia fighting for breath, and then to further hamper its efforts by ordering poultices weighing about a pound seems to me hardly a scientific procedure. I prefer a light jacket of Gamgee tissue or cotton-wool over which some stimulating liniment may be sprinkled. This may be left for hours or even days without disturbing the patient, whereas poultices require to be changed every three or four hours and there is always the risk of the patient being chilled by a cold poultice or scalded by one too hot.

Lastly comes the question of feeding. It seems to me that during acute pulmonary affections more food is forced down the patient's throat than he requires and, moreover, that nourishment is given at too frequent intervals. The drawbacks of over-feeding the patient are very forcibly put in a paper read at the International Medical Congress at Berlin by Dr. Andrew Smith of New York. "The anxiety 'to keep up the strength' and the apprehension excited by the small and feeble radial pulse are apt to suggest the administration of more food than is necessary or beneficial. We forget that the digestive organs are not in a condition to do the work demanded of them in health and also that the pulmonary obstruction interferes with the process of hæmatosis. Giving an excess of food therefore entails a double embarrassment. There is the burden arising from undigested food in the stomach giving rise to flatulent distension and thus rendering respiration more difficult, and there is also the risk of loading the blood with more nutritive material than the imperfect respiration can act upon in the process of sanguinification." In all acute affections, unless vomiting be present, nourishment should not, as a rule, be given oftener than every two hours, and about five ounces of milk, or the equivalent, are usually sufficient. I cannot help thinking that the success which attends one's treatment of pneumonia and enteric fever in hospital practice is largely due to the regular administration of a moderate quantity of nourishment.

In the above remarks I have only briefly touched upon some of the important points in the care of the sick, but from my experience in consulting practice I am convinced that too little attention is bestowed on the necessity of laying down clear and precise directions as to the hygiene of the sick room and the diet of the patient.

Wimpole-street, W.

[2] Brit. Med. Jour., 1891, vol. i., p. 1008.
[1] THE LANCET, Oct. 26th, 1895.

SOME UNUSUAL CASES OF SWELLING OF THE PAROTID GLAND.[1]

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ASSISTANT SURGEON TO UNIVERSITY COLLEGE HOSPITAL AND TO THE VICTORIA HOSPITAL FOR CHILDREN.

I HAVE thought the following group of cases worthy of notice, imperfect as are the records of more than one of them, because they illustrate a minor ailment which appears to have passed almost unnoticed, at any rate in this country. It will be convenient in the first instance to record the brief notes of the cases as they have come under my observation and then to consider their probable nature and refer to cases presumably of the same nature which have been recorded by others.

CASE 1.—A thin, anæmic boy thirteen years of age came to the out-patient department of the Victoria Hospital for Children on Jan. 1st, 1892, on account of a swelling of the right side of his face which had appeared somewhat suddenly

[1] A paper read before the Harveian Society on April 16th, 1896.

during a meal a month previously and since then had become somewhat larger and harder. The boy had never had mumps nor was there any evidence that he had recently been exposed to the infection of that disease. On examination it was at once obvious that the swelling was due to enlargement of the right parotid salivary gland. The swelling was slightly lobulated, tender on pressure, in most parts hard, but, especially below the ear, slightly elastic. On squeezing the gland a string of turbid, ropy mucus could be expressed from the orifice of Stensen's duct into the mouth and this was followed by several drops of saliva. A fine probe could easily be passed along the duct, and no calculus or other obstruction could be detected. On the 6th the boy was admitted to the hospital on account of the increasing size of the swelling. It was still found easy to press a long plug of turbid mucus from the duct, after which a free escape of saliva always followed. Hot fomentations were applied externally and hot water mouth-washes were ordered to be repeated frequently. On the 17th the gland was still larger and the swollen socia parotidis was very obvious. The skin over the gland was reddened and the temperature reached 103·6° F. Movements of the lower jaw were very painful, but no increase in the size of the swelling was observed when food was taken. On the 19th the redness and œdema over the gland were so marked that suppuration was suspected. A short incision was therefore made below the ear and a Lister's sinus forceps cautiously pushed into the gland, without, however, finding pus. From this time the swelling slowly diminished, and on the 28th it was noted that the boy was free from pain. On Feb. 2nd the whole gland was still obviously enlarged and remarkably hard. On the 16th it was suggested that iodide of potassium liniment should be rubbed into the gland once daily. When the boy was last examined, on March 22nd, nearly four months after the onset, the gland was smaller but still very hard.

CASE 2.—A healthy-looking boy aged eleven years came to the Great Northern Central Hospital on April 4th, 1892, on account of a swelling of the left side of his face of about one month's duration. The swelling was said to have diminished slightly in size during the last fortnight. It was painful, especially at meals, but it was not stated that the swelling increased at these times. The boy was not known to have been exposed to the contagion of mumps. There was no history of any inflammatory affection of the mouth or throat. On examination the left parotid gland was found to be considerably swollen and tender. The swelling was slightly lobulated, but the socia parotidis could not be defined. Below the salivary gland a few slightly enlarged lymphatic glands could be felt. On pressing the parotid saliva flowed into the mouth from Stensen's duct. Hot water mouth douches were prescribed and belladonna liniment was rubbed into the parotid region. On the 7th pressure on the gland caused an escape of turbid mucus from the duct; the swelling was smaller and softer. A week later, when the boy was last seen, there was still further diminution in the swelling and mucus could no longer be squeezed from the duct.

CASE 3.—A man twenty-six years of age, whilst on a short railway journey in September, 1889, experienced a feeling of discomfort and slight fulness in the left parotid region. On the following day the swelling was much more marked and was exactly limited to the area occupied by the parotid salivary gland. It was very tender on pressure, and mastication was difficult on account of pain. With the taking of food the swelling appeared to increase. Although there was a history of mumps in childhood affecting, it was believed, both parotids, the diagnosis of mumps was made and isolation for a fortnight was strictly observed. At the end of a week the swelling had practically disappeared. During the next three or four years several milder attacks occurred in which the left parotid gland was obviously swollen and slightly tender for periods of a few days. Frequent abortive attacks were noticed in which the socia parotidis alone was swollen and tender for a day or two, and at the present time, six and a half years after the first attack, this part of the gland can still be felt to be slightly enlarged and indurated.

CASE 4.—A thin, ill-tended child aged fifteen months was brought to the Victoria Hospital for Children on Jan. 7th, 1896, on account of a swelling of the left side of the face and neck, which when it was first noticed, five weeks previously, was thought to be mumps. The swelling had gradually increased, but appeared to cause the child no pain. No history of any trouble with the mouth or throat could be obtained. The child, although very ill-nourished, presented no other symptom of inherited syphilis. There was congenital ptosis on the left side. The swelling for which advice was sought was due to uniform enlargement of the left parotid salivary gland, which was sufficiently marked at once to attract attention. The swelling was very hard, but did not appear to be tender. Nothing abnormal could be seen in the position of Stensen's duct. A week later the gland was perhaps slightly smaller.

CASE 5.—A man aged thirty-three years came to University College Hospital on Feb. 19th, 1896, on account of a swelling in the left parotid region. This had gradually been increasing for two months; it was said to be most marked in the morning, but had not been noticed to increase during meals. The swelling had the characteristic outline of the parotid gland, but the socia parotidis could not be separately defined. The swelling was uniformly firm to the touch; it was free from pain and tenderness, but caused some discomfort during eating. The skin over the gland was normal. Pressure failed to squeeze anything from Stensen's duct, and I was unable to pass a fine probe along it. There was no evidence of the presence of a calculus. The mucous membrane of the mouth and throat appeared normal. The patient's general health was not good and for several years he had been under treatment for stricture of the urethra.

In reviewing these short records it will be observed that in each instance we have to deal with swelling of one parotid salivary gland. In none of them was there any difficulty in excluding a swelling due to enlarged lymphatic glands, for although this may sometimes closely resemble a swelling of the parotid itself, in these cases the outline of the enlargement was quite characteristic.

Passing to the consideration of the probable nature of the cases, it may be remarked in the first instance that they were not mumps, although in more than one case the condition had been confused with that affection. Amongst the many reasons which might be adduced in connexion with this point I may mention (1) the absence of any known exposure to the contagion of mumps; (2) the prolonged course of the swelling; (3) the limitation of the swelling to one parotid gland; and (4) the absence of infection of other individuals. Continuing the process of exclusion I may say that in each case the presence of a salivary calculus was duly considered and negatived. In the large majority of cases the essential symptom of a salivary calculus is swelling of the gland due to obstruction of the duct, but there is a specimen in the museum of University College illustrating chronic enlargement and induration of the submaxillary gland resulting from the presence of small calculi in its substance. The gland was excised by Mr. Godlee, who, before proceeding to the operation, believed that he had to deal with a tuberculous lymphatic gland. The course pursued by my cases excluded such a condition. Lastly, there were no grounds in any instance for referring the case to the parotid inflammations which are known as "symptomatic parotitis" or "parotid bubo," such as may occur in the course of pyæmic processes, typhoid fever, &c., or to the group, for our knowledge of which we are so much indebted to Mr. Stephen Paget, in which parotitis complicates various abdominal diseases and injuries, at times apparently independently of sepsis.

Passing from the negative to the positive, I may express my belief that the above cases are examples of swelling of the parotid gland resulting from interference with the escape of its secretion due to inflammation of the lining of Stensen's duct. This conclusion was suggested by the fact that in Cases 1 and 2 pressure on the swollen gland caused the escape of a plug of thick, turbid mucus from the duct, followed by a free flow of saliva. In Case 3 also it will be observed that in each attack the swelling affected first the socia parotidis and in the slighter attacks did not extend beyond it. Remembering that the socia parotidis has a small duct of its own which enters Stensen's duct, it is easy to understand that a slight degree of inflammation, insufficient to block the main duct, might completely obstruct the smaller one.

I have been unable to discover that any particular attention has been drawn to such a condition in this country, but in the article on Diseases of the Salivary Glands in Duplay and Reclus's "Traité de Chirurgie" I have found several interesting references to cases probably belonging to this category. Kussmaul[2] records a case of "recurring salivary tumour resulting from fibrino-purulent inflammation of Stensen's

[2] Berliner Klinische Wochenschrift, 1879, No. 15.

duct." The patient, a woman thirty-two years of age, experienced attacks of swelling of the right parotid gland, recurring every five or six months between the summers of 1875 and 1877. The swelling always appeared somewhat suddenly during meals, and was attended with a feeling of discomfort but no actual pain; it lasted for about half an hour and then rapidly subsided. In the summer of 1878 an attack of more considerable swelling occurred, of longer duration and attended with much pain, especially during meals. The swelling subsided after the escape of some drops of thick pus from Stensen's duct. The attacks now recurred more frequently, sometimes after intervals of not more than two or three weeks, and on one occasion the swelling lasted eight days. No treatment beyond the application of dry warmth to the cheek was adopted. Dr. Krieger, who treated the patient, found that the masses which escaped from the duct consisted of pus and fine filamentous cylinders, the fibrinous nature of which was demonstrated microscopically by Dr. Friedländer. The patient was taught to pass a fine platinum wire sound along the duct and thus obtained relief, for on withdrawing it thick fibrino-purulent matter escaped and after this a free flow of saliva. At the beginning of November, 1878, another attack occurred in which not only the right gland, but to a much slighter degree the left, was affected. After the patient's midday meal Kussmaul found great swelling in front of and below the right ear, the skin was red and hot, and pressure was painful. The sound could be passed only a few millimetres along the duct, but on withdrawing it some yellow, creamy pus escaped, followed by a filamentous thread and clear saliva, after which the sound could be introduced for four centimetres. In an attack in January, 1879, the thread which escaped was three centimetres long and as thick as a knitting needle. This was examined by von Recklinghausen, who found that it consisted of a fine membranous deposit composed of a network of fibrin containing pus and epithelial cells. The patient was seen some time subsequently and had had no further attacks. A chlorate of potash lozenge was taken daily. Another case which is worthy of notice was published by Berthold Stiller of Budapest.[3] A man aged thirty-six hurriedly summoned Dr. Stiller on account of a rapidly increasing swelling of the right cheek which appeared during dinner. The swelling corresponded with the right parotid gland and was the seat of a sensation of warmth and discomfort but not of actual pain. Nothing unnatural could be seen in the mouth. Dry heat was applied to the cheek but did no good, for on the following day the swelling was larger and painful. Whilst the patient was handling and squeezing the swelling he spat out a shreddy purulent mass, whereupon the mouth filled with a clear watery fluid. The swelling rapidly diminished and on the following day had disappeared. Subsequently the patient experienced milder attacks every three to six months, and the swelling was invariably relieved by pressure applied to the gland. These two cases afford strong support to the view that I had independently formed as to the nature of at least the first three of those which I have recorded. In both the rapid subsidence of the swelling after relief of the obstruction in the duct shows that it was due simply to retention of secretion and not to inflammation of the gland. In my cases, on the other hand, the persistence of the swelling and induration would point to the occurrence of inflammation of the gland lobules of a kind comparable to that which may occur under similar circumstances in other secreting glands, notably the breast. In Cases 4 and 5 evidence that the primary mischief was in Stensen's duct is wanting, but I strongly suspect that these were also of the same nature.

As perhaps throwing a side light on the subject it may be mentioned that two cases of recurrent swelling of both parotid glands in association with xerostomia or "dry-mouth" have recently been recorded. In Battle's case[4] both parotids had alternately increased and diminished in size for a period of two years, and whilst the patient was under observation and the glands were at their minimum size the smaller was as large as a walnut, and both were firm and lobulated. In Chappell's case[5] the parotid glands "would suddenly enlarge at times, become tender, and after two or three days gradually subside." Whilst the patient was first under observation, in May, 1894, "both parotids were much enlarged, especially the right, and seemingly consisted of three or four nodular masses which were hard and non-sensitive and resembled those of a patient with mumps." In February, 1895, the glands had increased considerably in size. It may be considered probable that in these cases an inflammation of Stensen's duct, associated with the unhealthy condition of the mouth, was the cause of the parotid swellings. A condition similar to that under consideration has been met with in the submaxillary gland by Ipscher.[6] He was hurriedly summoned to a man aged thirty on account of a swelling which had suddenly formed in the right submaxillary region. Before Dr. Ipscher arrived the patient had relieved himself by pressing on the swelling when "a small white thread" appeared in the mouth followed by "a quantity of sour-tasting water." The right submaxillary gland was still considerably swollen, and the corresponding part of the floor of the mouth was reddened. This was the third attack, and in each of the two previous ones pressure on the swelling had been followed by a similar result. This case was published as the result of Kussmaul's communication, and was regarded by Ipscher as of the same nature. The only instance of swelling of the submaxillary gland, possibly belonging to this class of cases, which I have observed was that of a boy eight years of age who was brought to the Victoria Hospital on Feb. 9th, 1894. The swelling in the neck formed during the night in the winter of 1892 and did not subside for eight months. In November, 1893, it reappeared, and when I saw the boy the swelling evidently involved the right submaxillary salivary gland. There was nothing abnormal in the appearance of Wharton's duct, and a probe could easily be passed along it. Three weeks later the gland was smaller. The nature of this case was obviously doubtful.

I have thought these cases worthy of being recorded, although necessarily incomplete in many respects, because they illustrate a condition of some importance, if only on account of its superficial resemblance to mumps. It is a useful rule of practice always to examine the duct of a swollen salivary gland. If there is any probability that the swelling results from blockage of the duct by inflammatory products the regular passage of a fine probe may be expected to give relief, but induration of the gland is likely to persist for a considerable period.

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[3] Wiener Medicinische Wochenschrift, 1881, No. 19.
[4] Transactions of the Clinical Society, 1896, p. 282.
[5] New York Medical Journal, Feb. 29th, 1896.
[6] Berliner Klinische Wochenschrift, 1879, No. 36.

SOME CASES OF VENTROFIXATION OF THE UTERUS.

BY HASTINGS GILFORD, F.R.C.S. ENG.

I VENTURE to bring forward these few cases because the discussion on the subject of ventrofixation of the uterus by the British Gynæcological Society gives them some value from a statistical point of view. But apart from this they are, I think, worthy of publication owing to certain special features of interest. Thus, in one case the operation was done because of the perforation of the uterus by a curette. In another intussusception of the bowel set in after the operation, resulting in self-cure. In two of them both ovaries were also removed. In four Keith's operation was performed.

CASE 1.—A woman aged thirty-five years had severe prolapse of the uterus for five years and had suffered much from enlarged and painful ovaries. No pessary could be tolerated and she became thin, haggard, and utterly dispirited from constant pain and uneasiness. Both ovaries were removed in June, 1893, and the uterus was sewn to the edges of the wound with four silk sutures. It was nearly eighteen months before she had fully recovered her health, but now she is in an excellent condition.

CASE 2.—This patient was a woman aged thirty years. Keith's operation was advised owing to persistent pain in the right ovary and retroflexion of the uterus, but the left ovary being found unhealthy at the time of operation was also removed. This was done on April 18th, 1895, and so far as the displacement is concerned the result is satisfactory, but the ovarian disturbance, though better, has not yet disappeared.

CASE 3.—In November, 1894, I was asked to see a woman

aged twenty-six years with a view to the operative treatment of a band which could be felt in the upper part of the vagina, apparently dragging the cervix towards the right and tilting the uterus to the left. The uterus was also displaced backwards and the left ovary was large, prolapsed, and excessively tender. The patient herself was anæmic and depressed by two years of ovarian disturbance which had resisted all treatment. The band was first cautiously divided without influencing the displacement, and then Keith's operation was performed by clamping the left ovary externally. Convalescence was retarded by the appearance of white leg on the left side on the fourteenth day. She is now, however, in good health.

CASE 4.—This patient had suffered from pelvic trouble for six years and had been treated by various gynæcologists without permanent benefit. In the beginning of 1892, when I first saw her, her husband was abroad. Her symptoms were then not of sufficient severity to render an operation necessary, but in the summer of 1894 her husband returned and, her symptoms becoming progressively worse, it was decided that the case should be taken in hand. I found, on examining under ether, that the right ovary was enlarged and so displaced as to bring it under the fundus of the uterus, which was bent down over it. After six weeks' futile treatment by rest in bed, hot-water irrigations, and pessaries I removed the ovary by clamping the pedicle in the wound. She made a speedy recovery and is now quite well.

CASE 5.—In January, 1893, I was consulted by a woman aged twenty-nine years for pelvic pain and metrorrhagia. I found she had an enlarged and retroflexed uterus from which there had been a discharge of blood for five weeks, following amenorrhœa of six weeks' duration. She was given an anæsthetic, and after I had removed the products of conception the uterus was carefully curetted with a blunted "sharp" curette and irrigated with boiled water. It was then noticed that less water came out than flowed in, and a sound was passed which, to my horror, went in up to the handle without a hitch. It was now evident that the fundus of the uterus had been perforated by the curette, and on taking into consideration the size of the aperture, the fact that the discharge from the vagina was offensive, and that some of the contents of the uterus had been washed into the abdominal cavity, it seemed best to perform an abdominal section. The necessary instruments were therefore sent for and prepared while the anæsthetic was continued. On opening the abdomen and inspecting the uterus it was found that an irregularly star-shaped hole had been made through the highest part of the fundus. It was quite closed, and the edges, though ragged, were neither soft nor bruised. After washing out the abdominal cavity with boiled water the fundus of the uterus was sewn to the anterior abdominal wall in such a way that the part adjacent to the perforation was extra-peritoneal. Catgut sutures were used to attach the superficial layer of the uterus to the peritoneum of the abdominal wall, while two silk sutures transfixed the parietes and went deep into the substance of the uterus, one above the aperture and the other below it. A little bloody discharge afterwards oozed from the fundus of the uterus, but in fourteen days the wound had closed and the uterus now remains firmly fixed in place. That which most surprised me in this case was not so much the complete absence at the time of any indications of the mischief I had done with the curette, though I had it well under control, as the lack of that softness or œdema of the uterine wall which one is led to suppose is usually present in these cases. The tissue of the uterus on inspection was seemingly of normal consistency. Moreover, the curette was apparently pushed and not scraped through the uterus, for the perforation was not at the sides where the scraping action of the instrument would come into play, but at the fundus where such an action would have been at a minimum. Writers (e.g., Mr. Lawson Tait[1]) have often called attention to the frequency of this accident, of the impossibility of always avoiding it, and of the rarity with which it is attended with evil results. But under the circumstances I have detailed I think it must be safer to deal with the uterus in the way I have indicated than to leave the matter to chance. The cure of the displacement is also of positive advantage to the patient. I do not think there can be any question that such a course is preferable to that of removal of the uterus, which has been suggested by some continental operators.

CASE 6.—This was of a similar nature to the preceding, except that the symptoms were more severe and the displacement had resisted all treatment. At the time the patient was placed under my care the bleeding had been going on for nearly three months and the discharge was offensive. After curetting the uterus Keith's operation was performed, the right ovary being clamped. On the second day, after the subsidence of the nausea due to the ether, she complained of griping pain across the middle of the abdomen attended with nausea and occasional eructations and vomiting. The pulse was 98. Sulphate of magnesium and enemata of soap and water, of turpentine, and of glycerine (4 oz.) were successively tried without result. Nothing but hot water was now given by the mouth, and after twelve hours the same aperients were tried again with good effect. The pinching pain and nausea and vomiting still continued at increasing intervals for nearly a month after this date, and the bowels acted loosely from two to six times a day. The temperature also went up each evening to 102° F., and dropped to the normal point in the morning. The abdomen became slightly tender and distended, but there were no local signs indicative of pelvic or abdominal mischief. On the fifth day the patient had a shivering attack, when the temperature rose to 102·5°. The uneasiness with which one regarded the continuance of these symptoms was, however, much lessened by the fact that the pulse was of good volume and not rapid, the tongue was moist, and the patient herself looked well and was free from the feeling of illness. On the sixth day the motions became exceedingly offensive. On the fourteenth day the mystery was partly cleared up by the protusion from the anus of a shred of membrane which stank horribly, and proved on inspection to be a piece of the entire thickness of the large intestine, triangular in shape, the base being six inches and the sides five inches long. No other pieces were found. Other symptoms continued, however, with diminishing severity for a month after the operation. Though never before so affected, she now suffered from mixed internal and external hæmorrhoids A rectal examination revealed nothing amiss. The patient is now, six weeks after the operation, steadily improving, and has lost all her symptoms save slight looseness of the bowels. For lack of any better explanation I attribute the complication that ensued in this case to intussusception of the colon from irregular contraction of its walls during or subsequently to etherisation. The case is a good example of the unforeseen accidents that are prone to attend all major operations. It serves to show that no abdominal section can be considered safe however simple the operation.

CASE 7.—This case was similar to Case 3. The patient was twenty-six years old and the results have been excellent.

In none of these instances has the uterus become again displaced. In none of them has there been any trouble with the bladder with the exception of frequent micturition for a few hours after the operation; and even that was present in only two cases. Pregnancy has not followed in any case. I prefer Keith's operation even when there is no ovarian disease because of the mortality which has hitherto attended the performance of immediate suturing of the uterus to the abdominal wall. This mortality I feel sure is far higher than may be inferred from published statistics, for I have myself heard of several fatal cases which have never been made public.

Reading.

[1] THE LANCET, Aug. 10th, 1895.

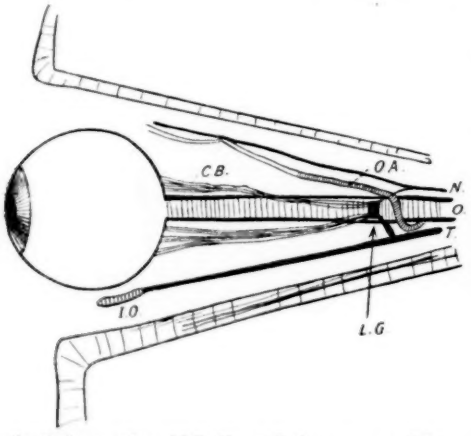
ON THE DISSECTION TO EXPOSE THE LENTICULAR GANGLION.

BY EDWARD FAWCETT, M.B. EDIN.,
PROFESSOR OF ANATOMY, UNIVERSITY COLLEGE, BRISTOL.

THIS is a ganglion which is often read about but seldom seen—at all events, satisfactorily. The object of this short communication is to point out how not only the ganglion but its minute branches and roots may always be demonstrated with no difficulty whatever. Most works on practical anatomy recommend the student to dissect the orbit from above. So far as the general contents of the orbital cavity are concerned this method is as economical and satisfactory, perhaps, as any, but it is extremely unsatisfactory so far as exposure of the lenticular ganglion is concerned. Professor

Macalister in his "Text-book of Human Anatomy" recommends the dissection of the orbit from the outer side. This method combined with the other gives the most satisfactory view of the orbital contents that can be obtained by the student.

Let us, therefore, suppose that we have removed the outer bony wall of the orbit and have cut through the periosteum of that wall; we will then be struck with the large size of the external rectus muscle which forms a broad covering for the orbital fat which is seen to project below its lower edge. Our duty is now to lift up the external rectus muscle as far as it is possible to do so; we may then raise the fat of the orbit from the lower periosteal wall of the cavity and in doing so we soon expose the inferior rectus muscle. Having exposed this muscle we proceed to make longitudinal cuts through the orbital fat till we expose a thick nerve trunk—that part of the inferior division of the third cranial nerve which goes to the inferior oblique muscle. Having secured this nerve trace it back to its origin, passing the back of the scalpel along its upper aspect; when near the apex of the orbit our progress is arrested by the emergence of a short and thick nerve trunk in length about one-eighth of an inch. This trunk is the motor root of the lenticular ganglion and by following it upwards and forwards the ganglion is found and recognised by its faint reddish appearance. Up to this point the dissection tallies almost exactly with that given by Macalister and is really based on his description. Now comes the essence of the dissection. The ganglion having been exposed, place the head on its side—that side away from the orbit which is being dissected down-



Lenticular ganglion of left side. O, Optic nerve. O A, Ophthalmic artery. N, Nasal nerve. T, Third nerve (branch to inferior oblique). I O, Inferior oblique muscle. L G, Lenticular ganglion. C B, Ciliary branches.

wards; now pour into the dissection some pure spirit and move it backwards and forwards with the end of the handle of the scalpel. In a very short time an almost magical effect is observed, for not only is the ganglion fully displayed, but every branch going to or coming from it is exposed too, and no further dissection with the knife is needed. The ganglion becomes a reality in the minds of students and not what I am afraid it too often is remembered as—something one sees in plates only. It is seen on the outer side of the optic nerve lying with its long axis placed vertically in the concavity of the ophthalmic artery—that concavity formed by the upward and forward bending of the artery on the outer side of the optic nerve. (*Vide* diagram.) The ciliary branches of the ganglion will be seen to pass forward from the antero-superior and inferior angles of the ganglion in two bundles which ultimately resolve themselves into many branches.

Bristol.

ROYAL BRITISH NURSES' ASSOCIATION.—The last sessional lecture of the season will be given on Thursday, April 23rd, at 8 P.M., at the offices of the Association, 17, Old Cavendish-street, W., by Sir James Crichton Browne, M.D. Edin., F.R.S., the subject being "Facial Expression."

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF DEXTROCARDIA.

BY P. N. GERRARD, M.B., B.CH. DUB.

IN January last I was called to see a female aged twenty-six years, well nourished but somewhat anæmic, who was suffering from orthopnœa and was in great bodily distress. She had always enjoyed fair health up to about two and a half years ago, at which time she had an attack of "rheumatism," but had recovered sufficiently to return to her employment. She was a dressmaker and used to carry large bundles of clothes and work the sewing-machine till late at night. Her heart seemed to have first felt the strain upon it about this date (1894), and her condition had gradually but steadily become worse until in February, 1896, the slightest exertion causing extreme dyspnœa and severe palpitation. Of infantile diseases she had had only scarlet fever and measles, both of them so mildly as not to have needed a medical man, and she had never had pleurisy. Her mother had hæmoptysis and three children of the family died in infancy. Her pulse was regular, somewhat more sudden than usual; the ulnar and digital pulse was well marked; the thorax was normal in shape, the breasts were not well developed, but otherwise she was well nourished. Her heart was in an unusual position, as was sufficiently evident from the rhythmical rising and falling of the right nipple. A fairly well marked *frémissement cataire* could be felt over the abnormal apex beat, which was situated on the right side and four and a half inches external to the ensiform cartilage. No impulse was to be felt in the normal position of the apex beat. The superficial area of cardiac dulness extended from the third right interspace downwards and outwards to the apex beat (in the position before mentioned) mingling with the hepatic dulness, and therefrom apparently extending on into the right axilla. At the apex a double murmur was heard, the systolic being transmitted into the right axilla and being well heard at the inferior angle of the right scapula; the point of maximum intensity of the murmurs was at the apex. Proceeding further to examine the conduction of the murmurs they were found to wane as the sternum was approached, their sound being replaced by a single localised presystolic murmur best heard about the junction of the right sixth costal cartilage with the sternum, which I took to be a tricuspid murmur. Over the aortic area a very distinct double murmur was heard in the normal aortic situation, the systolic being conducted along the great vessels with marvellous distinctness outwards as far as the external clavicular origin of the pectoralis major muscle; this murmur was very well marked indeed at the sterno-clavicular articulation. In the normal position of the pulmonary valve a systolic murmur was heard which was quite independent of the aortic systolic murmur and which was conducted on the left over an area of about two and a half inches in diameter round the normal position of the valve in the second left interspace. Hæmaturia was present when the urine was last examined about three weeks previously. The spleen, if enlarged, must be only slightly so, as I have never been able to palpate it below the ribs. The liver was apparently normal in size and position. The menses had always been scanty and pale. During a short period at the beginning of an acute attack of rheumatism, from which the patient is still suffering in some degree, the bases of both lungs were congested, but this had since cleared up, except on the right side, where there still remained some dulness. About the middle of February this year she had a sudden seizure in which, as described to me by her mother, "she sat up in bed and became so breathless and panting that it was thought she would be smothered, and kept groaning in agony with the pain in her side." I suspected embolism of a branch of the pulmonary artery to be the cause It was very difficult to examine the fundus oculi on account of the excitable condition of the patient, but I believe pulsation of the retinal vessels to be present in a marked degree. As the patient

has never had pleurisy or any acute disease, the rheumatism mentioned being of a mild character, I am inclined to believe the case to be of congenital origin.

Tamworth, Staffordshire.

BONNET-PIN IN THE MALE URETHRA.

By GERARD C. TAYLOR, M.A., B.C. CAMB.,

HOUSE SURGEON, STAFFORD INFIRMARY.

THE accompanying figure accurately shows the length (six inches) of a bonnet-pin I removed from the urethra of a young man last July. Two very similar cases were reported in THE LANCET of 1894.[1] In the present case the patient's account of the accident, though not so ingenious, was at least credible. He stated that a woman with whom he had been spending the evening passed the pin, head first, up his urethra and accidentally allowed it to slip from her grasp. On examination the point of the pin proved to be an inch and a half from the meatus. With a pair of serrated sinus-forceps I succeeded in getting a firm hold on the shaft of the pin close to the point, and extracted it without further difficulty. In both of the cases alluded to above the pointed extremity of the pin, directed towards the external meatus and lying a little distance within it, could not be disengaged from the urethra and was therefore thrust through the tissues as far as the head, after which the operator, having hold of the stem of the pin, was able to reverse its direction in the urethra and to pass it out of the meatus head first. In neither of these cases did the subsequent ill-effects amount to more than a little soreness on micturition lasting only for a day or two.

CASE OF REPEATED CHOLECYSTOTOMY.

By W. E. TRESSIDER, M.B., B.S. LOND.

THE patient, who was a female, first came under observation in December, 1893, complaining of jaundice, loss of appetite, indigestion, and weakness. She had been ailing at this time for five months, the illness commencing as a bilious attack after which she soon became jaundiced and remained so, the colour gradually increasing in depth until she came under my care. The illness had not been characterised by any severe attacks of pain, but chiefly by a feeling of nausea with indigestion and loss of appetite. After she had been under medical treatment for seven weeks I advised an operation, although no definite swelling could be felt in the region of the liver. The first operation was performed on Feb. 6th, 1894, but nothing definite was found. The gall-bladder was situated very deeply on the under surface of the liver, but nothing could be felt in it, and the abdominal wound was closed up without more than this exploratory procedure being accomplished. The symptoms after this continued much as before until the following June, when the patient had for the first time a violent attack of pain situated chiefly in the back, but also in the pit of the stomach. Her appetite, which before this had improved somewhat, again became very bad and she continued to get worse, having slighter recurrence of the pain, until July 25th, 1894, when, owing to a swelling having become perceptible over the region of the gall-bladder, I advised a second operation which was performed with the result that ninety-two calculi were removed. After this operation she was much better, regaining strength and weight, and for a time did not suffer much from either pain or indigestion, but this improvement was only temporary, for the pain recurred with increased violence, the patient lost strength and weight rapidly, and for a month or six weeks in October and November, 1895, she was in constant pain and almost entirely confined to bed. A third operation was performed on Nov. 30th, 1895, and calculi were again removed—a large one from the dilated common bile duct situated deeply in the abdomen, and eight others. Since this operation the patient has felt well; she has increased three stones in weight, her urine and fæces are now natural in colour, and she can eat ordinary food. This case exemplified a point to which attention has been drawn before—viz., that second and subsequent operations on the abdomen are accompanied by less shock than the first. Although little was done at the first operation the shock was very great, but it was slight at the later operations although the second occupied an hour and a half in its performance and the third more than an hour.

Nottingham.

[1] THE LANCET, Sept. 22nd and 29th, 1894

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De sed. et Caus. Morb.*, lib. iv. Proœmium.

LONDON HOSPITAL.

TWO CASES OF EXTRA-UTERINE GESTATION.

(Under the care of Dr. HERMAN.)

THESE cases form a useful contribution to the subject of ectopic gestation to which attention has been directed by the papers read before the Medical Society at a recent meeting.[1] It is not probable that the condition is becoming more common, but that operation is being more frequently performed in consequence of an earlier and better diagnosis with a more accurate knowledge of the gravity of the condition. The terms idiopathic peritonitis and pelvic hæmatocele are less frequently given as a final opinion of the nature of the patient's suffering; the cause of these affections is sought. The statistics of Formad show the general incidence of ectopic gestation, for in a series of 3500 general necropsies he found it in thirty-five instances. The reasons for operating when the hæmorrhage has taken place outside the peritoneum are suppuration in the hæmatocele, repeated hæmorrhage into the sac, or the continuation of fœtal life. The first of these cases will remind our readers that it is not always necessary to operate through the abdominal wall, as might be imagined from a consideration of the treatment adopted in the cases to which allusion is made above—those read before the Medical Society.

CASE 1. *Tubal pregnancy leading to tubal mole and intra-peritoneal hæmatocele; incision by the vagina; removal of tubal mole; recovery without bad symptoms.*—A woman aged twenty-eight years was sent to the London Hospital by Dr. Bate of Bethnal-green and admitted on Feb. 9th, 1896. She began to menstruate at thirteen years of age and had always been regular, the flow being scanty and painless. She had

[1] THE LANCET, March 28th, 1896.

had four children and no miscarriages. Her last child was born on Nov. 5th, 1894. She nursed the infant until December, 1895. Her first menstruation after the confinement was in October, 1895. Her last menstruation ceased on Jan. 13th, 1896. Soon after the last-mentioned date she took a hot bath and thought that she then caught cold. Ever since she had had bleeding from the vagina and pain in the lower abdomen. The bleeding was continuous every day, but not great in quantity. When admitted the patient was found to be well nourished but slightly anæmic. On abdominal examination a swelling was felt rising out of the pelvis two and a half inches above the pubes. By the vagina the uterus was found so pushed forwards and upwards that it formed the most prominent part of the abdominal swelling. Behind it was a convex, tense swelling bulging down Douglas's pouch. On Feb. 29th the swelling was larger. On abdominal palpation it was felt to reach to within three fingers' breadth of the umbilicus. By the vagina the uterus was found still further displaced forwards and upwards and the swelling behind it was as big as a fœtal head. By the rectum the swelling was felt to be altogether in front of it, not surrounding it laterally. There was no fever. The fixity of the swelling and the displacement of the uterus made it clear that the effusion was under pressure, not free in the peritoneal cavity. The absence of fever and the presence of anæmia and of slight uterine hæmorrhage made it probable that the effusion was blood. As it was increasing it seemed that the cause of the bleeding was still active, and that therefore interference was indicated. On March 3rd an incision big enough to admit four fingers was made in the posterior vaginal cul-de-sac. Fluid blood and clots came away. With the fingers the cavity was thoroughly emptied and examined. It had a firm concave roof. On the right side and behind a mass was found lodged in a cavity bounded by a fringed wall which projected into the main cavity. This was detached and removed. The fringed wall was plainly the open end of the Fallopian tube. The cavity, after being emptied, was loosely packed with iodoform gauze. The solid mass removed measured two inches by one inch and a half. It appeared to consist mainly of clotted blood, but at one part was a reddish-white solid lump about the size of the kernel of a nut, from which processes seemed to go out into the clot. This was afterwards examined microscopically and found to consist mainly of fibrin, among which were unmistakable chorionic villi. On the 6th the gauze was removed. The cavity was afterwards daily washed out with a saturated solution of boric acid. There was no fever. Small clots occasionally came away, but there was no considerable hæmorrhage. On the 24th the uterus was freely movable. The cavity behind it measured only an inch and a half in length. The patient went out well on April 10th.

CASE 2. *Tubal gestation; early death of the fœtus; subsequent hæmorrhage into closed Fallopian tube; removal; recovery.*—The patient, a strong, healthy-looking woman aged twenty-one years, gave the following history. She had been married two years and had had one child, born in May, 1894. She made a good recovery and nursed the baby. She menstruated for the first time after the birth of the child on March 27th, 1895. Excepting during childbed she had never been laid up, and since the delivery she had been well except for a little discharge of "whites." On April 26th, 1895, she was suddenly seized with pain in the left side of the lower abdomen. She fainted, and on recovering consciousness vomited, and there was a little bleeding from the uterus. With rest in bed the pain and bleeding gradually diminished, but four days afterwards it recurred as severely as before and the bleeding also returned. The symptoms gradually got better and she resumed her household duties. On May 12th the pain and bleeding again returned, and on May 18th she came to the London Hospital and was admitted. She had weaned the child shortly before admission. On abdominal examination there was some increased resistance low down on the left side. Examination by the vagina showed that slight hæmorrhage from the uterus was going on. The uterus was displaced slightly forwards and to the right by a swelling behind and to the left of it. The swelling felt elastic; its lower outline was convex; its upper limit did not reach higher than the fundus uteri; it was tender on pressure. Examination by the rectum revealed that the swelling did not surround the bowel, but reached to the pelvic wall on the left side. On June 9th the physical signs were much the same. The swelling was not larger. Since admission the patient had had two attacks of pain, each accompanied by increased bleeding from the uterus. For private family reasons the patient left the hospital. The patient returned to the hospital on June 18th. Since leaving it she had had several attacks of pain, accompanied by fainting and much more bleeding. On examination a rounded swelling was felt in the left lower abdomen. By bimanual examination it was found that the swelling in the left posterior quarter of the pelvis had increased to the size of a fœtal head. Operative treatment was therefore advised. On opening the abdomen the tumour was found to be the left Fallopian tube distended with blood clot. It was removed. The patient made a good recovery. The clot in the tube was carefully examined, but no trace of a fœtus could be found in it. Microscopic examination of sections of the wall of the tube showed unmistakable chorionic villi.

Remarks by Dr. HERMAN.—In Case 1 the increase in size of the swelling, indicating fresh hæmorrhage, pointed out the necessity of interference to remove its cause. There were two ways of doing this—by the abdomen or by the vagina. By abdominal section the general peritoneal cavity would be opened and the patient left with a scar in the abdominal wall, but the parts could be seen and treated with greater precision. This last consideration would make abdominal section better treatment than tapping by the vagina or making a small incision simply to let out the blood. In favour of approaching the disease by the vagina were the great bulging of Douglas's pouch and displacement of the uterus, which showed that the collection of fluid was quite shut off from the peritoneal cavity; hence this need not be opened and there would be no scar. By making a free opening, inserting the hand, and carefully examining the wall of the cavity, not only the blood was liberated, but the cause of the bleeding (the tubal mole) was found and removed. In similar cases I think this the best practice to follow. These two cases are instructive as illustrating a clinical fact—viz., that when the ovum in a tubal pregnancy has died, and the pregnancy as pregnancy has ceased to advance, the patient is not on that account free from danger; it cannot be said that the morbid condition is one which is innocuous and certain to get well if let alone. In both these cases considerable bleeding took place although the embryo must long have been dead.

KASHMIR MISSION HOSPITAL.

TWO CASES OF LAMINECTOMY FOR POTT'S DISEASE; REMARKS.

(Under the care of Mr. ARTHUR NEVE.)

MR. NEVE refers in his remarks to some of the principal reasons for performing the operation of laminectomy in cases of paraplegia due to spinal caries. We agree with him in the opinion that it is an operation which is rarely required, although from his statement it appears he has found it necessary in 10 per cent. of all cases seen at the Kashmir Hospital. As a rule we should operate only in grave cases in which acute compression, the appearance of respiratory or urinary complications, and the rapid development of degenerative processes force us to interfere, or in which the course of a chronic case is steadily toward a fatal termination although no advanced visceral tuberculous lesions are present. The opening of the spinal canal and the necessary manipulation of the cord has caused at times very severe shock, so that the idea of operating in such a manner as to get at the focus of disease without opening the spinal canal has been suggested to more than one surgeon. A procedure very similar to that which Mr. Neve has tried is credited to Dr. Ménard of Berck-sur-Mer. That surgeon makes a vertical incision at the point of greatest deformity through skin and muscles. One or two transverse processes are resected with gouge-forceps, also the posterior extremities of the corresponding ribs (subperiosteally). The periosteal canal of the removed ribs is followed with a curved director, the tuberculous focus in the vertebral bodies entered, and the diseased material cleared away. A double drain is then inserted and the cavity washed out with antiseptic lotion. He has had a certain amount of success with this method.

CASE 1.—A girl aged eighteen years was admitted to hospital with a prominent dorsal curvature and paraplegia of six months' duration. Both legs were much wasted and there was no voluntary movement, but in the left leg

exaggerated reflexes and ankle-clonus were present. In both legs she experienced morbid sensations as of ice or fire and needle pains, but there was no ordinary sensation. Her general condition was good. On Sept. 18th, 1888, the operation of laminectomy was performed on the eighth and ninth dorsal vertebræ. There was no trouble from bleeding; a saw was used for removing the bone. The membranes of the cord looked healthy and pulsated freely. The wound was closed and healed firmly within a fortnight. At first she complained a good deal of increased pain, and on the third day it was noted that she could move her left leg, but any hope of improvement soon died away; and when she was discharged from hospital a month after the operation the lower limbs were in the same paralytic state.

CASE 2.—A boy aged seven years had been paraplegic for only two months, though the curvature was of two years duration. The paralysis was very complete, being sensory as well as motor. Extension with weights and pulleys was applied to the head and the feet. After six weeks' treatment it was noted that "he seems to localise better when touched, also moves toes and draws up knees, but cannot straighten them." No further improvement took place till after operating. On June 21st, 1895, laminectomy was performed. The spines of the fifth and sixth vertebræ were severed with bone pliers, and then the corresponding laminæ. The dura mater looked healthy and the cord pulsated. At this moment the respiration seemed very embarrassed and it became necessary to turn the patient on to his back. The sensation in doing so was as if the upper and lower parts of the trunk were quite disunited, one of awful flaccidity. In a minute or two the pulse and respiration improved and the operation was resumed in a semi-prone posture. A drop or two of curdy pus was seen oozing from in front of the cord. This was syringed away, a little iodoform dusted in, and the muscular and skin layers carefully apposed with catgut sutures, not leaving any aperture for drainage. The wound was not seen till July 3rd, when it was found healed under the original dressing. Already sensation and power were returning. Ten days later the wound reopened and a little over one ounce of pus was discharged. He was taken away to his own village on Aug. 7th; at that time there was still some discharge from the sinus. In December he came to the hospital again and walked unassisted into the consulting-room. Both sensation and power had returned, but he was still in an emaciated condition.

Remarks by Mr. NEVE.—Operative interference in cases of Pott's disease has been rare in the past and will probably be no more frequent in the future. Except in those instances in which abscesses have to be dealt with, operations can only be indicated when the function of the spinal cord is affected by pressure—in other words, when there is paraplegia. The occurrence of paralysis in Pott's disease is variously estimated at from 8 to 30 per cent. But Mr. Muirhead Little[1] states that in over 75 per cent. of such cases the patients recovered power over their limbs under treatment by rest and extension. As some of those cured were paraplegic for months, it is evident that hasty operation is to be deprecated. There is a residuum of from 2 to 5 per cent. of cases in which the patients are hopeless without operation; but many of them are unsuitable for any severe operative measures owing to extreme debility, general tuberculosis, or other complications. So the scope for laminectomy is but small. Spinal caries is far from common in Kashmir. The hospital serves a population of over a million, but probably less than twenty cases of Pott's disease have been seen in the last ten years. Of these, four cases have been operated on—two on account of paraplegia and two in which abscesses had burst in the dorsal region. It is the former which are now in question. When Macewen[2] published his splendid series of laminectomy cases it seemed as if the usual cause of paralysis in Pott's disease was the presence of a connective tissue tumour (hypertrophic pachymeningitis) pressing upon the cord. A similar case was also published by Mr. Wright,[3] but such has not been the experience of Mr. Arbuthnot Lane,[4] who has usually found direct pressure by an abscess on the cord or occasionally bony narrowing of the canal. Nor in the two cases recorded above was there any noteworthy thickening of the spinal meninges. In the paraplegia of Pott's disease diagnosis does not keep pace with the possibility of treatment. In any given case the surgeon wants to know what is the pressure-producing condition. If it is recent (as in Case 2) and due to bony narrowing or to thickening of, or deposit on, the membranes laminectomy may be necessary as well as beneficial, but it must be remembered that it weakens the spinal column. It has been proposed in Pott's disease to wire the spines of the vertebræ together. This is a comment upon laminectomy. It is noteworthy that in the above cases, as in others which have been recorded, improvement was connected with the evacuation of purulent matter. Such abscesses are usually anterior to the cord. It might be well in operating, after exposing the posterior surface of the laminæ, to pass a trocar forward between the transverse processes and explore both sides of the body for pus, which is present in a large percentage of cases. If found, the surgeon would then leave the posterior portion of the vertebræ uninjured and would direct his efforts to the anterior disease. In two cases of dorsal caries unaccompanied by paralysis I have endeavoured thus to attack the seat of disease. In both there were sinuses leading inside the thorax. The first case occurred in 1882 and the second in 1888. They were almost identical. In both the transverse processes of two vertebræ and portions of ribs were removed and the side of the bodies of the vertebræ gouged. In the first case the patient, when apparently convalescent, died quite suddenly from an unknown cause, possibly the bursting of an abscess inwardly. The other patient made a good recovery. All the above harmonise with the published accounts of other cases. They show that operation is not devoid of risk and often fails to afford relief; but with careful selection of cases and, of course, thorough asepsis the risk is worth running for the sake of benefiting one here and another there whose condition is otherwise hopeless, and with further experience better results may be expected.

[1] THE LANCET, July 23rd, 1892.
[2] Brit. Med. Jour., vol. ii. 1888, p. 308.
[3] THE LANCET, July 14th, 1888.
[4] THE LANCET, Oct. 31st, 1891.

Medical Societies.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

Note on the Endemic Fever of the Mediterranean.

AN ordinary meeting of this society was held on April 14th, the President, Dr. DICKINSON, being in the chair.

Surgeon-Captain M. LOUIS HUGHES communicated a note on the Endemic Fever of the Mediterranean. He said that no suitable name had yet been suggested for this specific form of fever, nor was there any heading in the official nomenclature of diseases under which it could be returned. For the purposes of the paper it was termed "Mediterranean fever." It was endemic in various parts of the Mediterranean, and possibly in the Red Sea and elsewhere, while it also occasionally occurred in the form of localised epidemics. Though it appeared to have existed in Malta and Gibraltar since the beginning of the present century it was first accurately described by Dr. Marston in 1861 and had only found a place in English text-books during the last three years. Clinically this fever had a peculiarly irregular temperature curve, consisting of intermittent waves of pyrexia of a distinctly remittent type. These waves of pyrexial intensity were separated by periods of apyrexia or abatement of severity, giving a peculiar relapsing character to the fever. In some instances the daily remissions became so marked that the temperature might become intermittent (but non-paroxysmal) in character. Its duration was long and indefinite, the average pyrexial duration being from sixty to seventy days, the average stay in hospital over ninety days, while cases had been known to suffer from the pyrexial condition for over six months. This pyrexia was accompanied by progressive anæmia, a tendency to constipation, swelling and effusion in various joints, profuse perspirations, and a peculiar irritability of the nervous system characterised by sciatica and other neuritic symptoms. Pathologically the spleen was enlarged and softened, many of the organs were congested, but the intestines were free from ulceration. The microscopical appearances were those of toxic irritation of the tissues. A definite species of micro-organism (discovered by Bruce in 1886) was constantly present in those tissues where from clinical symptoms and post-mortem appearances it might be expected to be present.

Pure cultures of the "micrococcus militensis" produced by inoculation into the tissues of monkeys a similar form of pyrexia and in all other points fulfilled the postulates laid down by Koch. The disease prevailed during the hot dry months between May and October, with a maximum prevalence in July, August, and September. It was not contagious, nor did there appear to be any close connexion between its prevalence and the milk, water, or food supplies. Its dissemination appeared to be brought about on shore by an aerial infection arising from drains or soil infected by the excrement of previous sufferers from the disease. By this means it entered the human system by way of the throat or air-passages. Its prevalence followed an inverse ratio to the amount and continuance of the rainfall. The mortality did not exceed 2 per cent. of cases, but the duration of sickness was very long. No specific drug at present in use would cut short the disease. Successful treatment consisted in aiding nature by careful nursing and dietary, by confinement to bed during the acute stages, by such symptomatic treatment as might be required, by removal from all sources of reinfection, and last, but by no means least, by a moderate regulation of temperature by the external application of cold, whereby fatal results were averted and severe cases converted into mild ones.

Dr. THIN said that when in Malta last autumn he endeavoured to find out if this disease was connected with malarial fever. He carefully examined the blood of six patients in different stages of Mediterranean fever to see if the parasite of malaria could be found in the blood. He could discover neither parasites nor pigment in the blood or the spleens of those whom he examined. Typhoid symptoms were characterised by their absence, and the intestinal lesions were not of typhoid nature. One characteristic of the disease seemed to be that the patients were quite unaware of the gravity of their condition. Professor Pisani of Malta had told him that whereas formerly the fever was confined to those parts of Malta where English soldiers or sailors were commonly present it was now common in the country districts. In the neighbouring island of Gozo the fever was formerly absent and patients were sent to convalesce there, but now the fever had taken root there as well. The fever was the most serious disease connected with Malta, and it was of the utmost importance to the Government to devise means to check its ravages. It occurred probably in other parts of the world, such as Hong-Kong, where a fever of the same type as that described had recently reappeared. In Sicily the disease was formerly not known, but there was an epidemic in 1872. For some years afterwards a few sporadic cases occurred; then in 1884 an epidemic broke out at Catania and also in country districts where the air and sanitary conditions were beyond suspicion. Cases also occurred on the sides of Etna. It was a fever with an absence of symptoms that were specific or pathognomonic, and in most instances there was excessive sweating. At the apex of the lung a condition was often present which suggested phthisis but was not so. He held that the Government should take steps to have the fever fully investigated.

Dr. NORMAN MOORE said that Dr. George Cleghorn, in a book on the "Diseases of Minorca," described an affection which was clearly Mediterranean fever, and which was existent in Minorca between 1740 and 1751, at the time when the island was occupied by our troops. Dr. Cleghorn was of course prejudiced with the old classification of fevers and he regarded this as a variety of tertian, but his descriptions were very clear and he recorded 100 post-mortem examinations. He mentioned that definite destructive ulceration of the mucous membrane of the large intestine sometimes occurred; that certain varieties of skin rash appeared in the course of the affection; and that it was often complicated with pleurisy, and doubtless under this term he included croupous pneumonia also.

Dr. PATRICK MANSON said that he had had but little experience of this affection. He had seen several cases in London and one or two in China. In Hong-Kong he had seen a patient suffering from what he now thought must have been Mediterranean fever. In Amoy he once witnessed an epidemic of a fever in which there were two pyrexial waves separated by an apyrexial interval. As our knowledge became more accurate a great variety of fevers would no doubt be found to exist. From what was known of the affection under discussion it certainly was not malarial and not typhoid. Every credit was due to Surgeon-Captains Bruce and Hughes for the work they had done on the subject.

MEDICAL SOCIETY OF LONDON.

Osteitis Deformans.—Tumour of Liver associated with Jaundice.—Lymphatic Obstruction of Lower Extremity.—Congenital Angeioma of Neck.—Lateral Spinal Meningocele.—Spontaneous Dislocation of Patella.—Hairy Mole of Face—Sarcoma of Rectus Abdominis.—Cervical Rib.—Carcinoma of Larynx.

An ordinary meeting of this Society, for the exhibition of clinical cases, was held on April 13th, the President, Sir JAMES CRICHTON BROWNE, being in the chair.

Dr. DE HAVILLAND HALL exhibited a man aged forty-eight, who was the subject of Osteitis Deformans. The left leg had been noticed to be getting larger for seven years and the head for two years. The enlargement of the head was more on the right side and the maximum circumference was 25¼ inches. The lower jaw was slightly thickened but the face was not otherwise involved. The left tibia and femur were especially thickened, the right to a less degree. There was also angular curvature in the lower dorsal vertebræ. He had suffered from much pain which he referred to the bones and it was noteworthy that this had been quite relieved by the administration of quinine with iodide of potassium.—Dr. de Havilland Hall then showed a case of Tumour of the Liver associated with Jaundice. The patient was a man aged thirty-one, whose illness commenced with vomiting, pain in the abdomen, diarrhœa with clay coloured stools, bile in the urine and irritable skin. The liver dulness extended below the umbilicus and the organ was painless on palpation. He remained in the hospital nearly three months and on his discharge was still jaundiced. Dr. Hall regarded the case as one of hydatid cyst and looked upon the jaundice as catarrhal in character, spreading up from the duodenum into the common duct.—Dr. de Havilland Hall likewise showed a case of Lymphatic Obstruction of the Left Lower Extremity. The patient was a female aged twenty-five who had suffered from a swelling of the foot for four years. There had been no pain. The swelling extended up the leg to the thigh. The patient had never lived out of England. On admission there was a bluish discolouration of the leg, which disappeared on the adoption of the recumbent position. The leg was kept at rest, was bandaged, and iodide of iron with iodide of potassium administered. The leg was enormously swollen, did not pit on pressure, and the condition appeared to be allied to elephantiasis.—Mr. CLUTTON asked if there had been vesiculation. All the cases he had seen had presented a warty condition about the malleoli, and there were dilated lymphatic vessels which discharged a clear fluid. The cause of the lymphatic obstruction was difficult to find. If they occurred in young people the limb generally became elongated.—Mr. WATERHOUSE said that he had had had a precisely similar case under his own observation. The patient was a Jewish girl aged eighteen. The left leg was involved and no cause could be found, even after careful pelvic examination under an anæsthetic. On puncture of the limb ordinary lymph escaped. Martin's bandage was applied and this had produced a steady and continuous diminution of the circumference of the limb, which was one inch longer than its fellow.—Mr. G. R. TURNER asked if chyluria were present.—Dr. DE HAVILLAND HALL, in reply, said that the urine was normal and there had been no escape of lymph from the leg.

Dr. E. CAUTLEY showed a case of Congenital Distensile Tumour of the Neck. The patient was an infant aged five and a half months, who presented a swelling on the left side of the neck which became visible when the child cried. It lay behind the sterno-mastoid, but passed under that muscle. It was non-pulsatile and dull on percussion. He regarded it as a large venous angeioma.—Mr. BATTLE asked if there were any dulness in the upper part of the chest and whether the swelling had been tested with transmitted light.—Dr. CAUTLEY, in reply, said that the swelling was not translucent and that there was no chest dulness.

Mr. BATTLE exhibited a case of Lateral Spinal Meningocele. The patient was an ill-developed infant aged two and a half months who presented a congenital fluid swelling of the size of a goose's egg to the left of the upper part of the sacrum; the swelling presented alterations of tenseness when the child cried and it could be partly reduced on pressure, but the skin covering it was quite normal. A distinct deficiency could be felt between the posterior superior spine and the spine of the sacrum, and the poster r

superior spine was further away from the middle line than normal, being evidently displaced outwards.—Mr. Battle next showed the result of operation in a case of Spontaneous Dislocation of the Patella. The patient, a girl, was admitted to hospital in December last complaining of inability to walk far and a tendency to fall at times. The patella was found to have become dislocated on to the outer condyle of the femur, and on flexion to a right angle it slipped completely out of the intercondyloid groove. The quadriceps extensor was wasted, and this wasting was more marked on the inner side of the thigh. The external condyle was apparently ill-developed. Improvement followed osteotomy after Macewen's plan, but there was still a tendency to displacement outwards when the limb was fully flexed. This might probably be overcome by the use of special apparatus.

Mr. CLINTON DENT showed a case of Hairy Mole of the Face. The patient was a boy aged twelve, and the mole had been treated by repeated shaving of the cutis to get beneath the pigmentary layer. This shaving had produced a nævoid condition, and probably it would have been better to have excised the mole and applied skin grafts. It was remarkable that under the repeated shaving the hairs had become nearly white.—Mr. Dent also showed a woman, twenty-three years of age, with a Sarcoma of the Rectus Abdominis Muscle. The tumour appeared to be situated within the sheath of the rectus and was said to have at first diminished under the use of iodide of potassium. But it had increased markedly during the last fortnight, and other nodules could now be felt in its neighbourhood.

Mr. G. R. TURNER showed a case of Tumour of the Neck. The patient was a girl aged sixteen, who had only noticed the swelling of the neck for the last nine months; it had increased but slightly in size since November last. The swelling gave no trouble, except for numbness down the left arm. There was occasional grating on moving the scapula over the tumour. The mother had a bony swelling on the right side of her neck. They were both considered to be instances of cervical rib.—Mr. DENT doubted this diagnosis. He thought that there was a deformity of the ribs themselves, and a consequent displacement of the scapula.

Dr. GILBART SMITH showed as a card specimen a Larynx Affected with Epithelioma. It was removed from a man aged fifty-eight, who had suffered from his throat for six months. On examination it was found that the epiglottis was swollen and curled back; there was swelling of the right aryteno-epiglottic fold, and the space between the vocal cords was blocked by two or three excrescences springing from the base of the epiglottis. It would be thought that with such a condition the patient would have urgent dyspnœa, but as a matter of fact he did not suffer from dyspnœa till the day before his death. He died from heart failure a few hours after tracheotomy was performed. On examination the epithelioma appeared to have commenced in the neighbourhood of the epiglottis and then to have spread towards the right arytenoid cartilage.—Dr. DE HAVILLAND HALL said that if an obstruction were only gradually increased it could be borne without dyspnœa until the space for air entry was extremely small. He had recently seen a case which illustrated this fact.

CLINICAL SOCIETY OF LONDON.

Two Cases of Acute Abscess of the Liver.—Albuminous or Serous Expectoration after Paracentesis for Serous Effusion.—Sarcomatous Cranial Cyst.—Sequel to Case of Syphilitic Cranial Necrosis.

AN ordinary meeting of this society was held on April 10th, the President, Dr. BUZZARD, being in the chair.

Mr. R. J. GODLEE read the notes of two cases of Acute Abscess of the Liver. The first was one of pyle-phlebitis in a man aged forty-one years, who had an acute illness in June, 1895, which left him with pain in the region of the liver, for which he was seen in September. He had a hectic temperature and one rigor. There was obvious swelling of the liver. A drainage-tube was inserted. There was slight improvement for a day or two, which was not maintained. Post mortem there was old inflammation about the cæcum, clotting of the right branch of the portal vein, and the corresponding part of the liver was riddled with abscesses. The left portal vein was patent, and the left lobe of the liver was free from suppuration; the patient had also purulent meningitis. Remarks were made on the pathology and treatment of this condition. The second case was that of a previously healthy man aged fifty-eight. The disease began insidiously a month before he came under notice; there was very rapid enlargement of the liver accompanied by rigors. An abscess was found upon the under surface of the liver, containing about one pint and a half of stinking pus. The patient was very feeble before the operation and died of shock.—Mr. ARBUTHNOT LANE said that he remembered seeing a patient who was at first thought to be suffering from biliary colic, but the temperature rose to 103° F., and the gall-bladder became very distended and tender. On palpation he recognised that gall-stones were present, so he removed them in the usual way. The gall-bladder was adherent to all the surrounding structures, including the large intestine; he, therefore, made no attempt at exploration in its neighbourhood, but the gall-bladder was stitched to the skin and a tube left in. There was no jaundice. Two days later she had an attack of her old pain; the temperature was then normal, but it speedily rose as high as 107°, and the patient died seven hours later. At the post-mortem examination a large abscess was found behind the portal vein, and it was believed that this abscess had burst either into the main vein or into one of its branches.—Mr. SPURRELL asked why, in fixing the liver to the surface, Mr. Godlee had passed his sutures only half an inch into the organ.—Mr. GODLEE, in reply, said that the sutures were passed superficially because he believed that the pus was near the surface.

Dr. SAMUEL WEST read a paper on Albuminous or Serous Expectoration after Paracentesis for Serous Effusion. He said that it sometimes happened that during the paracentesis the patient began to cough and complain of some shortness of breath and soon after to expectorate a quantity of clear, frothy fluid. The cough was almost constant, though not very violent or paroxysmal, and with it there was some shortness of breath and, occasionally, also even considerable dyspnœa. Wheezing and crepitation were heard over the lung, usually over the affected side only, but occasionally on both sides. After the symptoms had lasted for an hour or two, or perhaps a little longer, they usually subsided and the case ran its ordinary course, but every now and then the symptoms were extremely severe and the patient died of suffocation. Albuminous expectoration was really very rare—one of the rarest events in pleuritic effusion. He related the case of a man aged about forty, who had a right-sided effusion for about three or four weeks. He performed paracentesis himself, using the syphon and not the aspirator. The fluid flowed readily, and after about forty ounces had been withdrawn the patient began to cough. The cough increased in frequency and caused much distress. This was soon followed by a little dyspnœa. Expectoration commenced in about ten minutes, and in an hour the patient brought up about eight ounces. The attack lasted for three hours, during which a pint of frothy fluid in all was coughed up. Over the right side (the side of effusion) there was a good deal of wheezing and crepitation, and a little also on the left. The patient's condition was in no wise such as to cause alarm, the symptoms rapidly subsided, and the patient made a good recovery. The cases of albuminous expectoration differed a good deal *inter se*. The attacks usually came on during paracentesis or immediately after it, sometimes as long as two hours. They lasted for a short time, usually not more than an hour or two, but occasionally longer. The quantity of fluid varied from a few ounces to even more than three pints. In character it was frothy, like that of acute bronchitis. It contained much mucin and little albumin. The physical signs were those of congestion of the lungs. There appeared to be no necessary relation between the duration of the pleurisy prior to paracentesis and the liability to serous expectoration, but, as a rule, the cases had lasted some little time. It was not to be connected with the use of the aspirator, for some of the cases, as in the present, occurred when the fluid was removed by the syphon only. The result was rarely fatal, and among the fatal cases some complication besides the effusion was generally found. The condition seemed less common than it used to be twenty or thirty years ago, probably because of the earlier performance of paracentesis. There were three explanations given of the phenomenon: 1. Perforation of the lung during paracentesis and the discharge of the pleural effusion through the lung; but the difference of the chemical characters of the two fluids showed that this explanation could not be correct. 2. The absorption of effusion by the lung. 3. Œdema of the lung; and this was the only

satisfactory theory. In the non-fatal cases this œdema must be due to some transitory condition and was probably in most cases to be connected with the sudden distension of the lung after it had been collapsed for some time. In the fatal cases some organic lesion was generally found in addition which would account for the result. In some of them the lesion was such as would cause obstruction either of the vessels of the lung or of the bronchial tubes and possibly also of the lymphatics; in others there was disease of the opposite lung—e.g., general pleural adhesion or morbus cordis. The subject had been brought before the society with the object of eliciting the experience of others, especially as to its frequency, which appeared to be very much less than it was commonly stated to be, for the present instance was the only one which had come under Dr. West's observation out of a very large number of cases of pleural effusion.—Dr. DE HAVILLAND HALL said that when collecting materials for a paper on pleurisy some years ago a search into the literature showed that the only cases then recorded were foreign. The only case he had since met with was reported from the Canterbury Hospital in December last. These cases were not only exceedingly rare, but also of considerable gravity. He agreed that the condition was probably due to œdema of the lung, and for treatment he would try dry-cupping followed by sinapisms to the chest, while internally he would recommend nitrite of amyl or nitro-glycerine.—Dr. HALE WHITE referred to the case of a patient who was recently admitted into Guy's Hospital suffering from pleurisy with effusion. For four or five days after aspiration she expectorated albuminous fluid in considerable quantities. After the first aspiration the temperature began to rise and a second collection of fluid was forming which might necessitate a second aspiration.—Dr. F. L. BENHAM said that he could not understand why, if this phenomenon were due to pulmonary œdema, it was not met with in œdema from ordinary causes. He thought it more probable that there was thrombosis of the pulmonary vessels.—Dr. WEST, in reply, said that pulmonary thrombosis had been commonly observed in the recorded instances of this disease, and he agreed that this was a very probable explanation. It was rare for the expectoration to go on for more than forty-eight hours. In the minor cases no active treatment was required, while in the acuter forms there was not time to carry out treatment.

Dr. NEWTON PITT and Mr. ARBUTHNOT LANE gave the details of a case of Cranial Cyst of Sarcomatous Origin. The patient in 1891 first complained of pain on the top of his head where he found a soft area. He paid little attention to this condition till September, 1893, when it bulged outwards, forming a tumour as large as an egg. This swelling gradually subsided. On four occasions it became enlarged and painful, subsiding by the discharge of a considerable quantity of serum through an orifice which formed in the scalp. He was first seen in November, 1892, when the swelling measured about two and a half by two inches. It fluctuated and also pulsated distinctly. A few days after its contents discharged themselves, about an ounce being collected and examined, when it was found to be simply serous. A depression three-quarters of an inch deep replaced the swelling and was bounded by a thin, irregular bony margin, which in parts yielded slightly to pressure. In December, 1892, the scalp over this area was freely divided, when a space was exposed which extended some little way beneath the overlapping edge of bone. Covering the whole of the floor, being most abundant at its limits and destroying the overlapping bone, was a quantity of some material which was apparently sarcomatous in structure. This structure was verified by subsequent examination. As the growth was so soft and extensive it was not felt advisable to remove such a large area of bone and dura mater as would be required for its entire elimination, so the wound was closed. Since the operation, except for a temporary leakage of serum and for a subsequent attack of erysipelas, the patient has enjoyed excellent health and has had no return of the headache from which he suffered previously to the operation.—Mr. MAKINS said that he recollected a case which resembled that under discussion. A patient presented himself at hospital with a large tumour of the upper jaw of less than a year's growth and attended by severe hæmorrhage. There was a distinct history of syphilis, but the tumour did not present the usual characters of a gumma. The upper jaw was removed and the base of the skull scraped. The wound healed by primary union, and the patient left the hospital in a fortnight. About three years afterwards the patient came back with a recurrence, there being a large, open ulcer, with thick edges, which involved nearly the whole of his cheek. He was told that nothing further could be done for him, and he returned home. After a time the tumour underwent shrinkage, and in the course of five or six months it had entirely cicatrised. As to the question of its being a gumma, several competent microscopists were strongly of opinion that the appearances were those of a sarcoma. Other cases of this kind had been placed on record.—Dr. NEWTON PITT, in reply, remarked on the very small amount of growth that was present in this case compared with the amount of fluid.

Mr. H. W. PAGE related the sequel to a case of Syphilitic Cranial Necrosis recorded in the twenty-eighth volume of the Transactions of the society. The patient in July, 1894, had had compression of the brain and frequent convulsions, satisfactorily dealt with by trephining over the right Rolandic area and the removal of a large quantity of broken-down gummatous material from between the dura mater and the bone. A large piece of necrosed eroded bone was taken away at the same time. The lesions were obviously syphilitic. The patient returned to his work and was free from fits until early in November, 1895, when they suddenly returned and rapidly regained their former frequency, numbering from four to ten every hour. The fits seemed to begin in the left hand or the left angle of the mouth, but so quickly became general that it was impossible to be certain on this point. The site of the former operation was exposed, but no fresh disease was discoverable either there or in the immediate neighbourhood, and it was obligatory to desist from further exploration, as there was nothing in the symptoms to show where disease lay. It was strongly suspected that there was a cerebral gumma beyond surgical interference. The fits continued to increase in frequency and severity and in two days the man died exhausted. At the necropsy a large broken-down gumma, which it would have been impossible to remove, was found in the right frontal lobe.—Mr. CLEMENT LUCAS related the case of a woman who was supposed to have Cancer of the Breast. There was a ragged ulcer of one mamma exposing a costal cartilage. There was dulness over the lung on the same side, with the usual signs of pulmonary consolidation. Syphilis being suspected, she was given large doses of iodide of potassium without producing any appreciable result. Some weeks later she became subject to epileptic fits, in one of which she died. Post mortem the lung was found to be fibrous throughout, and a tumour was discovered growing from the dura mater and projecting into the frontal lobe. Other signs of syphilis were present.—Dr. CHAPMAN inquired if in Mr. Page's case the patient had been treated with iodide of potassium in the interval between the first and second attacks.—The PRESIDENT asked if an ophthalmoscopic examination was made on the patient's second admission. The lesion of the frontal lobe did not account for the motor disturbances, which were present up to the time of the fatal result. The tumour in the Rolandic area might really have been present when the patient was first seen, for such lesions had more than once been observed to exist without giving rise to any indication of their presence. Although fits might be relieved by an operation performed for epilepsy, yet they might return later perhaps because of the formation of cicatricial tissue at the site of the operation, and this cicatrix might act like a neoplasm and press upon the brain surface. Cases such as these were extremely difficult of explanation.—Mr. PAGE, in reply, said that the patient was put upon iodide of potassium when he left the hospital, but he had not followed systematic treatment. When first in the hospital large doses of iodide produced but little appreciable effect. It was possible that the fits might have been set up by the presence of the cicatricial tissue, but against this was the fact that the subjacent membranes were practically healthy. He referred to the case of a patient who suffered from fits due to some lesion in the Rolandic area, and in him the first indication of a gross lesion was the appearance of the growth through the scalp. It was syphilitic and was dealt with as in the case now related. The patient died from pyæmia and during the last illness the surface mischief gradually extended. He likewise mentioned another case at present in hospital of a boy who came in with a scalp wound which had been suppurating profusely for three weeks. On exploration a minute opening was found in the bone from which pus escaped. On trephining a large abscess was found in the frontal lobe, which was drained, and the child

was now nearly well. There had been no cerebral symptoms before the operation, but the boy's temperament had altered and he had become bright and cheerful. There had been no fever or paralysis.

OBSTETRICAL SOCIETY OF LONDON.

Supposed Miscarriage at the Sixth Week of Gestation.—Deciduoma Malignum.—Exhibition of Specimens.

AN ordinary meeting of this society was held on April 1st, Dr. CHAMPNEYS, President, being in the chair.

Mr. MALCOLM read notes of a case in which a Miscarriage at the Sixth Week of Gestation was supposed to have taken place on Sept. 28th, 1895. On Dec. 20th the patient became very ill. She was admitted to the Samaritan Free Hospital and a perforation of the uterus was discovered. Death occurred on the 24th. Post mortem new growths were found in the uterus, the right broad ligament, the mediastinal glands, and the lungs.—Dr. HEBB reported that the growths were sarcomatous, and showed sections.

Mr. ALBAN DORAN communicated (for Mr. RUTHERFORD MORISON) a case of Deciduoma Malignum occurring in England.

Dr. HERBERT SPENCER read notes of a case of Deciduoma Malignum. He gave a full clinical history and post-mortem record of a case of this kind occurring in 1889, the first case, he believed, observed in this country. The disease occurred in a young Danish woman twenty-seven years of age, a secundipara, whose previous labour took place at the age of twenty years. The first symptom of the disease—passage of masses of the growth—occurred twenty-eight days after a normal labour, which was followed by a normal puerperium. Subsequently there was a fœtid discharge of masses of growth and of blood, and the disease ran a septic course, terminating fatally within ten and a half weeks of delivery. At the necropsy an ulcerated and gangrenous growth was found at the placental site, the ulceration and gangrene having nearly perforated the fundus. Secondary growth was also found in the cervix and in the lungs, but nowhere else in the body. The growth in all three situations was similar and was characteristic of deciduoma malignum, being apparently a large celled sarcoma with the typical "syncytium." A full account of the microscopic appearances was given. The necessity of early diagnosis and treatment by vaginal hysterectomy was pointed out.

Dr. EDEN read a paper entitled "Deciduoma Malignum: a Criticism." He referred to the number of cases of malignant uterine growth occurring subsequently to gestation which have been recently recorded, mostly by German observers. The most important cases were those of Sanger, Gottschalk, Marchand, and Whitridge Williams. Sanger introduced the term "Deciduoma malignum." He thought that in his case the tumour arose in the decidua and was composed largely of so-called "decidual cells." Dr. Eden believed that cells precisely like those found by Sanger occurred in the uterus under various conditions, and did not prove the origin of the growth in the decidua. Gottschalk believed that in his case the growth arose from a "sarcomatous transformation" of the stroma of retained chorionic villi. Whitridge Williams's case possessed the general characters of a sarcoma; tumours were present in the uterus, vagina, and vulva, and it was not clear which was the primary growth. He relied for his diagnosis upon the presence in the tumours of plasmodial masses which he believed to be syncytial in origin. Marchand records two cases, in both of which he found similar syncytial masses; he also claimed to have found cells derived from the fœtal ectoderm. In one case represented as a tubal gestation in a girl aged seventeen years there was no anatomical evidence of pregnancy discovered. The tubal mass may therefore have been a primary malignant growth. Dr. Eden believed that plasmodia not unlike those figured by Williams and Marchand as syncytial masses were frequently found in sarcomatous growths in other parts of the body, and doubted whether there was sufficient evidence to justify the view that they arose from placental relics. The case recorded by Mayer was referred to in which there seemed to be proof of the origin of a malignant growth in retained myxomatous villi (hydatiform mole).

The following specimens were exhibited:—

Dr. WILLIAM DUNCAN: Hæmato-salpinx with Torsion of Tube.

Dr. SPENCER: (1) Modified Ferguson's Speculum; (2) a skiagram of a Sireniform Monster; and (3) lantern slides illustrating his paper on Deciduoma Malignum.

Dr. GALABIN: (1) Myxo-sarcoma from the Urethra in a Child; (2) Sarcoma of the Cervix Uteri; and (3) Microscopic Sections from Material removed from the Uterus after Miscarriage (? Malignant).

Dr. CULLINGWORTH: Ruptured Tube and a Three Weeks' Embryo from the Sac of an old Pelvic Hæmatocele.

EPIDEMIOLOGICAL SOCIETY.

Puerperal Mortality in England and Wales from 1847 to 1895.

A MEETING of this society was held on March 20th, Mr. SHIRLEY F. MURPHY, President, being in the chair.

Dr. W. WILLIAMS, medical officer of health of Glamorgan, read a paper on Puerperal Mortality in England and Wales from 1847 to 1895. The subject, he said, was one of national importance, for though the experience of lying-in hospitals had shown puerperal mortality to be eminently preventable the number of women dying in childbed had not diminished and was about 4000 annually. These deaths were referable: (1) to puerperal fever, and (2) to accidents of childbirth, such as exhaustion, hæmorrhage, and convulsions. Calculated on the number of registered births the mean annual death-rate was 4·9 per 1000, or 2·0 from puerperal fever and 2·9 from accidents. The puerperal fever death-rate attained the maxima of 3·6 in 1874 and 3·3 in 1893, the latter being a remarkably dry year in which the mortality from typhoid fever, diphtheria, and diarrhœa was very high. The highest death-rate from accidents during the period under review was 4·5 in 1847 and the lowest was 1·9 between 1886 and 1889. The apparent increase in puerperal fever about 1874–75, when the Public Health Acts came into force, might be the result of a more uniform nomenclature. In the successive periods ending in 1854, 1864, 1874, 1884, and 1894 the death-rates from puerperal fever were returned as 1·72, 1·56, 1·78, 2·28, and 2·53, and those from accidents as 3·01, 3·07, 3·03, 2·24, and 2·41, the latter showing a marked reduction during the last twenty years, but the former steadily rising. Deaths from puerperal fever were twice as frequent in early life, and those from accidents fewest between the ages of twenty-five and thirty-five, rising rapidly afterwards. Primiparæ were specially liable to puerperal fever. From the returns since 1884 it appeared that the mortality from puerperal fever, which was 2·0 per 1000 for the whole country, ranged from 2·4 in Lancashire and 2·2 in Wales, Cheshire, and Northumberland, to 1·0 in Surrey. The conditions of the population varied greatly within each county, but generally the mortality was higher in those west of a line drawn from the mouth of the Tees to that of the Severn. That from accidents of childbirth ranged from 4·1 in North and 3·7 in South Wales to 1·9 in Rutland, the mean being 2·9, the highest rates being in Wales and the border counties and the lowest in Essex, Hants, Leicester, and Rutland. Taking the Welsh counties severally, the death-rate from puerperal fever was above the average for England and Wales in seven counties and below it in four. The highest and the lowest total mortalities alike were met with in purely agricultural counties, though it seemed that the mountainous districts had the higher death-rates. The population of the county of Glamorgan had increased tenfold since the beginning of the century and had doubled within the last thirty years, comprising at present more than half that of the entire principality, or at the last census 693,072 persons, of whom not more than 25,000 or 30,000 lived under strictly rural conditions in the peninsula of Gower and the Vale of Glamorgan. From an analysis of the density of the population and the social conditions of each registration district the conclusion might be drawn that puerperal fever was generally, though by no means always, excessive in the most insanitary localities; that the mortality in the larger Welsh towns did not differ much from that of towns in other parts of the kingdom; and that the prevalence of puerperal fever in the thickly peopled mining valleys was to a very great extent due to the general employment of ignorant midwives. The death-rate from accidents of childbirth, which for the whole Principality was not much above that for the rest of the kingdom, was very unequally distributed, being excessively high in these mining valleys, where, however, there ought to be no serious difficulty in obtaining

medical assistance. In an epidemic of puerperal fever, of which a detailed account was given, the part played by the midwife was evident; the cases were chiefly among easy natural labours and primiparæ, and there was no connexion between this disease and scarlet fever which prevailed at the same time, the few parturient women who contracted scarlet fever being in no instance attacked by puerperal fever. Expectant mothers ought to be instructed in the duties and responsibilities of the puerperal state, and every woman should be taught the elements of nursing, with special reference to parturition and infectious diseases, for which, as a branch of technical education, classes should be formed by the county councils, who might also undertake the training of midwives whose practice should be, so far as possible, watched by the medical officer of health. Notification must be made universal, and on the occurrence of a case of puerperal fever the medical officer and his inspectors should forthwith see to the remedying of any sanitary defects and the disinfection of the premises, bedding, &c., suspending the midwife for a time.

Dr. WILLOUGHBY, pointing to the maps, maintained that no relation existed between the physical features of a district and the puerperal mortality. He did not believe that any specific fever, except erysipelas, could give rise to puerperal fever, and he attributed its frequent occurrence after easy natural labour to inefficient evacuation of the uterus. For many years he had always effected this completely by introducing his hand, and had avoided the exhaustion of tedious labour by using the forceps in the majority of his cases—precautions to which he ascribed the immunity of his patients from puerperal fever and hæmorrhage.

Dr. BOXALL held the same opinion as the last speaker with regard to erysipelas and other acute specific fevers. He could not explain why puerperal fever, although stationary in the provinces, seemed on the increase in London, where deaths from the accidents of childbirth were diminishing. The liability of primiparæ to laceration rendered them more susceptible of infection. He believed that it was useless to instruct ordinary midwives in antiseptic methods.

HUNTERIAN SOCIETY.

Perityphlitis.

A MEETING of this society was held on April 8th.

Mr. PERCY WARNER read a paper on a case of Perityphlitis. The patient, aged thirty-five years, was suddenly taken ill on July 24th, 1895, with pain in the renal region running in the direction of the ureter, marked tenderness in front and behind, vomiting, and rise of temperature. There was also a rigid condition of the muscles on the right side of the abdomen and frequent micturition. No well-defined tumour could be made out until convalescence was established. The patient had a relapse on Sept. 9th, with great pain and much swelling above the crest of the ilium. Mr. Charters Symonds operated and a quantity of foul pus was discharged. The patient made a good recovery. Mr. Warner remarked on the frequency of micturition, which at first suggested a renal origin of attack, but showed how the variability in length and position of appendix would account for the varying site of pain after suppuration has taken place. The position of the pain depends on the position of the abscess, which in the case related was situated at a point on the crest of the ilium at the junction of the posterior and middle thirds, where the abscess had burrowed out of the iliac fossa into cellular tissue of the gluteal region. The tenderness behind was remarkable. He pointed out that the treatment of this disease might be divided under the three forms of the malady: (1) Simple perityphlitis; (2) perityphlitic abscess, probably due to perforation; and (3) perityphlitis followed by general peritonitis due to acute perforation. The great difficulty consisted in deciding when to operate, and he remarked that no two symptoms can determine this, and that he relied not only on local signs, but also greatly on the general condition of the patient. He also referred to the important question of surgical treatment in the early stage and quoted the opinion of American surgeons, who advocated the removal of the appendix in all cases of perityphlitis. Lastly, he pointed out that in cases of relapsing typhlitis there was a fair consensus of opinion that the operation should be done in the quiescent period.

Mr. CHARTERS SYMONDS, after making supplementary remarks as to the operation, gave an account of his experience in such cases and referred to the fact that symptoms of perityphlitis were simulated sometimes by malignant disease, suppurating kidney, and active mycosis, and are occasionally apt to resemble typhoid fever. He considered it doubtful whether in acute cases an operation can be performed too early, and showed a perforated appendix removed from such a case with successful result.

The PRESIDENT, Dr. F. J. SMITH, Dr. H. SEQUEIRA, Mr. HOPE GRANT, and Dr. ARTHUR DAVIES took part in the discussion, and Mr. WARNER replied.

BRITISH GYNÆCOLOGICAL SOCIETY.

Adjourned Discussion on Ventro-fixation and Suspension of the Uterus and Allied Operations.—Exhibition of Specimen.

A MEETING of this society was held on April 9th, Dr. CLEMENT GODSON, President, being in the chair.

Dr. BANTOCK said he had never performed any of these operations. He had been able to afford complete support in all uncomplicated cases by means of a properly constructed diaphragm pessary with or without a plastic operation. When he opened the abdomen it was never on account of displacement, but on account of the condition of the appendages.

Mr. MAYO ROBSON read a short paper (communicated by Mr. Reginald Harrison) by Dr. O'Conor of Buenos Ayres, giving his experience of Ventro-fixation of the Uterus, which he had performed eight times with satisfactory results.

Dr. ELDER (Nottingham) had performed Alexander's operation in several cases some years ago, but gave it up for three reasons: (1) the uncertainty of finding the round ligaments; (2) the results were not permanent; and (3) it was not devoid of risk. In uncomplicated cases he had found curetting and plastic operation sufficient, and, like Dr. Bantock when he opened the abdomen in cases of adhesions, it was not because of the displacements, but because of the condition causing it. He had seen many fashions in gynæcology, and he thought that ventro-fixation was one of them which would not last.

Dr. ALEXANDER (Liverpool) thought his operation had not been quite fairly represented by some of the speakers at the last meeting and he wished to correct two impressions: (1) that it was a double abdominal section; and (2) that the results were not permanent. 1. He recapitulated the steps of the operation, showing that the abdominal cavity was not opened, and maintained that there was absolutely no risk in it, but some of the modifications of it which had been introduced were both unnecessary and dangerous. 2. Results: The cases of failure were due to want of attention to certain details. In cases of prolapse a plastic operation was often necessary, but he could not agree with Dr. Bantock's pathology of the condition. The first step in prolapse was the falling back of the uterus, and his operation cured this, not by drawing up the uterus, but by anteverting it. When there was retroversion he always inserted a Hodge pessary to keep traction off the round ligaments till they were firmly united in the wound. It was easy to tell when union had occurred, because pressure on the external abdominal ring caused traction on the cicatrix. When the uterus was also retroflexed he introduced a stem pessary for three weeks, keeping the patient in bed. In some of his earlier cases, where these precautions were not adopted, the condition recurred owing to tension on the yet ununited ligaments. He then gave in detail the after-histories of a number of his cases and said he felt justified in maintaining that the operation was efficient. He had in all performed several hundred operations. He admitted that there was a slight tendency to hernia in some cases, but had always found that this tendency, when it existed, could be readily controlled by a truss.

Dr. WINSON RAMSAY (Bournemouth) showed a Uterus from a patient aged fifty-five. In February, 1894, he performed ventro-fixation for prolapse. A year later she returned with the cervix protruding through the vulva. Thinking that the stitches had given way he performed hysterectomy, but then found that the cervix was elongated and that the fundus was still firmly attached to the abdominal wall. She made a good recovery.

Dr. WILLIAM DUNCAN, speaking at the President's invitation, said that Dr. Ramsay's specimen was interesting as

illustrating supra-vaginal elongation of the cervix; but he presumed the condition existed at the time of the first operation. His experience of Alexander's operation was very different from that of Dr. Alexander; he performed it eleven times some years ago. Unlike Dr. Elder, he found the operation itself quite simple, but all the cases relapsed within four months. He did not use a stem pessary because he regarded it as a dangerous instrument.

Dr. LEITH NAPIER remarked that the first patient he operated on was now pregnant for the third time. He asked Dr. Alexander whether he found his operation practicable when there were adhesions; it seemed to him that in such a case the round ligaments might be ruptured, as happened twice to Edebohls of New York. He did not think more than three sutures were necessary in ventro-fixation; if the adhesions were too firm trouble arose during pregnancy.

Dr. HEYWOOD SMITH used only one suture in his first case, which was quite successful. The discussion illustrated the progress of public opinion, for he performed the first case of deliberate ventro-fixation twenty-two years ago, and THE LANCET in commenting upon it hoped that as it was the first it would be the last.

Dr. ALEXANDER, in reply to Dr. NAPIER, said that he operated at once when there were no adhesions; but when these were present he treated them by rest in bed with douches and tampons, by which they were readily overcome. He did not consider there was any danger in the stem pessary; as he used it he kept it in only while the patient was in bed.

The PRESIDENT, in thanking Mr. Mayo Robson for coming up to London a second time at considerable personal inconvenience, said that the debate had shown that the operation of ventro-fixation was not one to be put aside, but to be used with proper limitations.

Mr. MAYO ROBSON, in reply, thanked the Fellows for their attention and for their interest in the debate. If these operations were not safe they should not be done; but the discussion had demonstrated their safety. When they could cure a patient without operation they should do so, but many cases would only yield to operation.

Dr. WINSON RAMSAY (Bournemouth) showed a Pedunculated Myoma of the Uterus which occupied the pelvis and led to intestinal obstruction.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

Infantile Scurvy.—Chemical Composition of the Carbohydrate and Albumoid Substances.—Exhibition of Cases and Specimens.

A MEETING of this society was held on April 10th, Dr. A. SYMONS ECCLES, President, being in the chair.

Dr. H. MENZIES read notes on a case of Infantile Scurvy. The patient was a male infant aged eleven months, the younger child of healthy, well to-do parents. He was well grown and until the present attack had always been healthy. After a few days' malaise on Feb. 18th of the present year his left eye suddenly swelled and became discoloured and all the classical signs of the disease rapidly developed—viz., loss of strength, pallor, limb swelling, proptosis of the left eye, spongy gums, bruise-like ecchymoses, and minute purpuric spots. A rapid disappearance of all the symptoms followed the administration of an anti-scorbutic dietary of fresh milk, raw meat juice, potato pulp, and orange juice. The case was interesting in two ways: (1) the absence of all positive signs of rickets; and (2) the danger of a long-continued use of sterilised milk, upon which the child had been brought up. After referring to the writings of Dr. Cheadle and Dr. Barlow on the subject, Dr. Menzies pointed out the curious fact that while authorities in England and America agree in recognising the scorbutic nature of the affection, many German and some Danish writers still regard as unproved this etiological factor, and maintain that rickets *plus* a hæmorrhagic tendency is the real malady—a view which seems to be opposed to all the evidence of its morbid anatomy and certainly contradicted by the result of dietetic treatment, for the rapid improvement which follows the administration of anti-scorbutics is one of the most remarkable facts in medicine.—Mr. ALBAN DORAN doubted whether sterilised milk was wholesome and nutritious, and suggested that some of our efforts at the exclusion of germ life might be misdirected.—Mr. KEETLEY considered that the advantages of giving sterilised food to infants quite outweighed its dangers, which could be averted by the addition of a due proportion of anti-scorbutics. He affirmed the distinction between infantile scurvy and rickets, which latter might be produced by more than one micro-organism, including that of syphilis.—Dr. H. SUTHERLAND believed that from a scorbutic standpoint the boiling of milk as usually practised was probably harmless, but the use of milk exposed to a very high temperature for a long time was not to be regarded as safe.—Dr. COUTTS believed that the milder forms of infantile scurvy were common and frequently unrecognised. He advocated the addition of anti-scorbutics to sterilised milk.—After remarks by Dr. THUDICHUM, Dr. BURRELL, Dr. KEEN, Mr. MORTIMER, and the PRESIDENT, Dr. MENZIES replied.

Dr. THUDICHUM read a paper on the Chemical Composition of the Carbohydrate and Albumoid Substances with special reference to Diabetes and its treatment.

Dr. DICKMAN showed a case of Localised Scleroderma.

Mr. ALBAN DORAN showed three specimens of True and False Capsules of Ovarian Cysts. 1. The patient was single, aged twenty-five. A small cyst filled the lower part of the abdomen and intestine lay in front; the fundus of the uterus could be felt in the right groin. No part of the cyst came down into the pelvis. On tapping a pint and six ounces of fluid escaped. On inspecting the tapping hole two distinct layers could be seen as though there were a true capsule. On pushing the hand down behind the supposed capsule the entire cyst was displaced with a normal pedicle. There were no adhesions and the opposite ovary was healthy. The "capsule" was simply the ovary itself distended by the cyst within its substance. The true cyst wall was connected with the ovarian capsule by very loose connective tissue. Had the union been close and firm that would have been the usual condition in ovarian cystoma and no two separate layers would have been seen on inspecting the trocar wound. On the other hand, had the capsule of ovarian tissue been adherent to pelvic structures the cyst might have been deliberately enucleated from the ovary itself; the appearance after enucleation would then have been puzzling. 2. Hypertrophied Tube on the Surface of an Inflamed Ovarian Cyst. The meso-salpinx adhered firmly to the cyst, so that at first the cyst seemed as though it had furrowed into its layers. This was a "false capsule cyst." 3. A Dissection showing the relations of a Cyst developed between the Folds of the Meso-Salpinx. The greatly elongated Fallopian tube runs on the surface of the wall of a similar but very much larger cyst, the greater part of which has been cut away. These are typical encapsuled cysts. Mr. Doran remarked on the non-identity of pathological and surgical cysts and on the grave results which might ensue on their confusion, for if the surgeon mistook these adhesions for a capsule and attempted enucleation, intestine, vessels, or the uterus might be damaged.

MIDLAND MEDICAL SOCIETY.

Exhibition of Cases and Specimens.—Pneumothorax.

A MEETING of this society was held on March 18th, Dr. UNDERHILL, the President, being in the chair.

Dr. J. HAZELWOOD CLAYTON showed a youth aged nineteen years who presented Enlargement, without evidence of secretion, of the Right Mammary Gland. The question discussed was whether the case ought to be regarded as one of inflammatory enlargement or as one of true hypertrophy induced by intermittent pressure from a carpenter's brace.

Mr. F. MARSH showed a little girl aged five years who last autumn had Scarlet Fever, followed by Post-scarlatinal Diphtheria (membranous laryngitis), necessitating tracheotomy. During convalescence she contracted measles. Attempts were made on several occasions to dispense with the tracheotomy tube, but without success, as asphyxia immediately became imminent. She was first seen by Mr. Marsh on Nov. 30th, and a laryngoscopic examination was made under chloroform. Considerable cicatricial stenosis somewhat cone-shaped was found in the upper part of the larynx, and a small probe only could be passed through into the trachea. On Dec. 11th the cicatrix was divided with Heryng's intra-laryngeal knife and a next to the largest size O'Dwyer's intubation tube introduced, the smaller sizes being expelled, probably owing to the shape of the opening. The tracheotomy tube was now removed and

the wound rapidly healed. On the 30th the intubation tube was removed, but as asphyxia threatened the largest size O'Dwyer's tube was inserted. It was decided to leave this in for a fortnight and then, if it could not be dispensed with, that a thyrotomy should be performed and the cicatricial bands excised. Unfortunately, on Jan. 8th symptoms of typhoid fever were noticed and a typical attack ensued. As the child was fairly comfortable and respiration was not embarrassed the tube was allowed to remain in the larynx until March 13th. Its removal on this occasion was successful, both respiration and phonation being more easily performed. Up to the date of publication (March 30th) steady improvement has taken place; there is only slight dyspnœa when the child runs fast, and the breathing is occasionally noisy during sleep. The voice, too, is improving; it is usually a hoarse whisper, but at times becomes louder and clearer.—Mr. F. MARSH also showed a youth aged twenty years who from childhood had had a purulent discharge from the right ear (a sequel of measles) and at intervals an abscess in the mastoid region. When admitted into the Ear and Throat Hospital pus was freely discharging from a sinus opening about half an inch above the external auditory meatus. He had never had any headache or illness, the only symptoms experienced being the purulent discharge and some slight pain with each abscess formation. The mastoid was explored on Feb. 22nd and beneath the orifice of the sinus was an opening in the bone about half an inch in diameter leading into a large cavity filled with fœtid putty-like débris. When this was removed the cavity was found to be quite two inches in diameter and would have held a Tangerine orange. The walls were of bone except posteriorly, where the cerebellum could be felt pulsating over an area about the size of a four-shilling piece. The upper limit was quite an inch above the superior wall of the meatus. The cavity was lightly packed with gauze and was now slowly granulating. The features of interest were the unusually large dimensions of the cavity and the total absence of sinus, meningeal or cerebral complications, although the meninges were in contact with the fœtid contents.

Mr. GEORGE HEATON showed a Sixpence which had suddenly been Expelled from a man's Right Bronchus five and a half years after it had been inhaled. The patient had suffered from repeated attacks of suffocative cough ever since swallowing the coin. A low tracheotomy was performed in 1891 and attempts made to remove the coin. He suddenly coughed it up in January last and has since lost all his symptoms. The coin was in three pieces and thickly coated with black scales of sulphide of silver.

Mr. HEATON also showed a large Uterine Fibro-myoma removed by Hysterectomy. The tumour, which weighed between ten and eleven pounds, reached as high as midway between the umbilicus and ensiform cartilage. It had lately grown rapidly and reduced the patient to a state of profound anæmia. The pedicle was treated extra-peritoneally with the clamp. The patient experienced little or no shock from the operation and was at present convalescent.

Mr. GAMGEE showed a specimen of Perforated Vermiform Appendix removed from a girl aged fifteen years. The symptoms began on March 1st, 1896, with a sudden attack of abdominal pain, but no vomiting. The pain continued for a week, when she presented well-marked signs of localised inflammation in the right iliac fossa. At the operation on March 8th four or five ounces of foul pus were evacuated and the appendix was removed. Vomiting, collapse, and death occurred nine hours afterwards. The post-mortem examination revealed general suppurative peritonitis. Attention was called to the absence of symptoms of general peritonitis, for the patient's condition appeared good. There was no vomiting till an hour or two before death, the abdomen moving freely. There was no general abdominal pain or tenderness.

Dr. SHORT showed a youth aged seventeen years (but who looked fourteen years) with a large Pulsating Tumour between the clavicle and the right edge of the sternum. There was loss of resonance on percussion, with a distinct thrill; presystolic and systolic mitral and aortic diastolic murmurs were present. Dr. Short thought that a saccular dilatation of the aorta existed between the valves and the arch, probably due to some congenital defect because the boy was of stunted growth; dyspnœa and slight cyanosis on exertion had existed since birth; and the general absence of symptoms was inconsistent with any recent origin.

Dr. SHORT also showed the Heart and Lungs from a baby four weeks old. There were beady vegetations on the curtains of the tricuspid valve which were thickened, two of them being joined together. The pulmonary valve was not affected. The left side of the heart was normal. From the appearance of the valve it was inferred that the endocarditis had commenced during fœtal life and had affected an imperfectly developed valve. The condition was a rare one. Death occurred somewhat suddenly at the end of the fourth week and was preceded by five attacks of acute dyspnœa unaccompanied by cyanosis. Portions of the lungs were imperfectly expanded.

Dr. FOXWELL read a paper on four cases of Pneumothorax occurring in healthy males who had suffered no previous illness or external violence. He believed the cause in each was the same—viz., the rupture of an emphysematous air sac. Recovery occupied from twenty to four weeks. The longer period was partly brought about by a relapse owing to unwise exertion and partly to the age (sixty years) of the patient. The patient who got well in four weeks was only nineteen years of age. In his case, too, two pints of gas were drawn off. Dr. Foxwell pointed out that, in his opinion, the chief cause of the re-expansion of the lung was the cohesive force of the two pleuræ, a force which was demonstrated by Dr. S. West in his Bradshaw Lecture to be nearly double the elasticity of the expanded lung. Regarding treatment, the importance of respiratory quietude and the advantage of removing the gas under the same circumstances as one would a liquid effusion were insisted upon.

MANCHESTER MEDICAL SOCIETY.

Treatment of Recurring Appendicitis. — Intra-laryngeal Photography. — Sensory Distribution of Spinal Nerve Roots.

A MEETING of this society was held on April 1st, the President, Dr. HENRY ASHBY, being in the chair.

Mr. SOUTHAM mentioned ten cases of Recurring Appendicitis treated by operation. In five cases the appendix was removed during the quiescent stage with satisfactory results. In one case, where the appendix was so surrounded by dense adhesions that it was unrecognisable, relief followed the breaking down of adhesions. Attention was directed to the fact that it was not uncommon for suppuration to occur sooner or later in recurrent appendicitis, and it was therefore advised that in order to prevent this complication the appendix should be removed after two well-marked attacks, especially if any induration or local swelling persisted after the subsidence of the attacks. In support of this opinion details were given of four cases of recurring appendicitis where suppuration had taken place; in three of these an encysted intra-peritoneal abscess was opened and drained with good results; in the fourth case, where there was a history of mild attacks recurring for several years, perforation of the appendix suddenly took place, followed by diffuse suppurative peritonitis, which proved fatal.

Dr. YONGE discussed the difficulties of Intra-laryngeal Photography. There was first the difficulty of obtaining a good actinic light of sufficient power to illuminate satisfactorily a cavity within a cavity such as the larynx happened to be. Direct sunlight was unavailable, magnesium light uncontrollable and otherwise inconvenient, and therefore an electric arc lamp was chosen for his experiments. Other difficulties were that of directing all the available light into the mouth, of illuminating the laryngeal mirror when it was so placed in the pharynx as to receive the complete laryngeal image, and the difficulty of holding the mirror in the patient's mouth so that it should appear illuminated to the lens of the camera, although to the operator's eye it might be in shadow owing to the fact that the angle at which his eye caught the illuminated image was different from the angle at which the lens received it. Other difficulties were gauging the exact length of exposure required and, lastly, keeping the mirror absolutely steady. The method adopted by Dr. Yonge—based on Mr. Lennox Browne's—was as follows. Dr. Yonge, who performed the experiments on his own larynx, seated himself before a camera into the cap of which a small looking-glass had been inserted. A large laryngeal mirror was introduced with the left hand and the tongue drawn forward with the right. The light of a 1000-candle power electric arc lamp—supplied by the Edison Swan Company—was then concentrated by passing the

rays through a 6-inch condenser and directed on the mouth. The carbons of the arc lamp were mounted on a projector and the whole apparatus formed a species of "search-light." As soon as the mirror was seen to be sufficiently illuminated by the reflection in the small looking glass placed on the cap a signal was given, the cap removed, and an exposure of one second allowed. Photographic laryngoscopy was of value (1) as showing the exact method of voice production; (2) as giving a truthful account of endo-laryngeal conditions; and (3) as a means of estimating the progress of a laryngeal case. Dr. Yonge gave a short lantern demonstration of photographs obtained by the foregoing method.

Mr. THORBURN then read a paper on the Sensory Distribution of Spinal Nerve Roots.

LIVERPOOL MEDICAL INSTITUTION.

Cell Granulations.—Exhibition of Specimens.—Leprosy in Iceland.

THE last meeting of the session was held on April 9th, Dr. BARR being in the chair.

Dr. BUCHANAN read a note upon Cell Granulations. He especially drew attention to the fact that in some of the white blood corpuscles two kinds of granules, basophil and oxyphil, were present. This, he said, had not been observed before. The paper was illustrated by some beautiful lantern slides.

Mr. LARKIN exhibited a Brain with a Temporo-sphenoidal Abscess following Middle-ear Disease; also a Pedunculated Tumour which he had removed from the neighbourhood of the nipple in a female subject. Mr. Hutchinson had reported three similar cases which proved to be adenomata. Mr. Larkin had not yet examined this tumour microscopically.

Dr. MOYLES showed for Dr. ALEXANDER: (1) Hernia through a Hole in the Mesentery, and (2) Syphilitic Disease of the Skull, &c.

Dr. ABRAM exhibited a Fibroid Heart and Thrombosed Femoral Artery. The latter had led to dry gangrene of the leg. Microscopical sections of the coronary arteries and the femoral revealed extensive disease of the interior and middle coats of both vessels.

Dr. GROSSMANN then read a paper upon Leprosy in Iceland. He narrated the history of the disease as given in the Icelandic chronicles, and pointed out that in the sixteenth century leprosy was frequently met with. He stated that leprosy was much more common in Iceland than was generally supposed, probably owing to the non-recognition of the anæsthetic variety. He did not believe in the hereditary transmission of the disease, at least to any extent, but considered it to be transmitted by contagion, a mode of propagation favoured by the almost indescribably bad hygienic conditions under which the majority of the Icelanders live. Dr. Grossmann illustrated his remarks by a series of excellent photographs of the anæsthetic and tuberculated varieties of leprosy.—Dr. HARRIS said that Dr. Haussen believed firmly in the contagious nature of the disease, and did not consider that bad hygiene and feeding had much influence.—Dr. ABRAM thought that hygienic conditions such as Dr. Grossmann had described, must afford a very good incubating machine for the bacillus lepræ. An analogous state of affairs is seen in beri-beri, where sailors keep the forecastle at such a temperature that some ships are never without cases on board, yet it never spreads among the saloon passengers.—Dr. LESLIE ROBERTS and Dr. BARR also took part in the discussion.

SHEFFIELD MEDICO-CHIRURGICAL SOCIETY.

Exhibition of Cases and Specimens.—Suppurative Cholangioitis.—Pathological Changes in the Cerebral Cortex of the Insane.

A MEETING of this society was held on March 26th, the President, Dr. PORTER, being in the chair.

Mr. SNELL introduced a patient aged thirty-three years, the subject of Acquired Nystagmus, due to the manner of work followed at his occupation. The man had been compelled to relinquish his employment on two or three previous occasions for lengthened periods owing to the distress occasioned by the subjective symptoms of the nystagmus. Mr. Snell referred to nystagmus in other occupations, remarking that if looked for the affection would be found to be associated with other employment and not entirely that of coal-mining. Since he had recorded some years ago the case of a compositor with acquired nystagmus he had met with other cases in the same class of work and had observed a fairly large number of instances in other occupations.—Mr. Snell also showed a girl aged eighteen years with Double Papillitis (passing into Atrophy), the result of plumbism due to her work as a file-cutter.

Dr. SINCLAIR WHITE showed a very large Gall-stone which he had removed by operation.

Dr. ARTHUR HALL showed specimens of (1) a Cerebellar Tumour the size of a hen's egg, sarcomatous, with secondary distension of the lateral and third ventricles to a very large extent. The affection had lasted eighteen months, and the gradual enlargement of the head was watched. Lumbar puncture was performed by Mr. Pye-Smith, but without benefit; in fact, it aggravated the pain and the boy died the following day. Two drachms of fluid were removed. 2. Hæmorrhage into the Pons extending over the base of the brain and into the left lateral ventricle. 3. Softening of the Right Optic Thalamus.

Mr. MARRIOTT showed: (1) An Intra-pericardial Rupture of the Aorta which showed marked atheromatous changes, and which was the seat of a small aneurysm at the point of rupture; and (2) a large Gall-stone from a patient under Mr. Lockwood's care which had been passed by the bowel without any symptoms.

Dr. ERNEST KNIGHT (Rotherham) read notes of a case of Suppurative Cholangioitis. The patient, a man aged forty-seven, fell ill at the end of October with symptoms of hepatic colic. The illness began with rigors and profuse sweating; slight jaundice was noticed two days after the onset of symptoms. It passed off in a week. The rigors persisted, however, and glycosuria developed. There were considerable tenderness and fulness in the epigastric region. The glycosuria intermitted for a time, but reappeared one month before death, the rigors and sweats continuing daily and nightly up to the time he died comatose, which was in January, 1896. There was no return of jaundice; there were varying tenderness and fulness in the epigastric region. No operative measures were deemed advisable. Post mortem the liver was found to be much enlarged, the cystic duct entirely and the common duct partly blocked by several soft gall-stones, consisting largely of colouring matter, each about the size of a horse bean. The gall-bladder was empty except for a little thick bile. Suppuration extended up the ducts through both right and left lobes and formed numerous small abscesses; the lobulus quadratus was converted entirely into an abscess cavity. The kidneys were small with atrophy of the cortex.

Dr. RAY (Wadsley) read a paper on Some Pathological Changes in the Cerebral Cortex of the Insane. Some introductory remarks were made on the fresh method of preparing brain sections, on the minute anatomy of the cerebral cortex, and on the neuroglia, its lymphatics and vascular system. The relation of the blood-supply to pathological changes was then dwelt on. The early changes in the cortex in insanity were described. The three stages of fuscous degeneration were illustrated by microscopical drawings and slides. Spider cells in the superficial layer of the cortex were demonstrated, and the nature and probable function of Deiters' cells were discussed. The paper concluded with some remarks on the nerve cell in idiocy.—The PRESIDENT, Dr. ARTHUR HALL, Mr. CUFF, Dr. BURGESS, Dr. ADDISON, Dr. SINCLAIR WHITE, Dr. RUTHERFORD, and Dr. MARTIN made remarks.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF MEDICINE.

Defective Metabolism in its Relation to Gout.—Acute Dysentery.

A MEETING of this section was held on March 27th, Dr. T. W. GRIMSHAW, President, being in the chair.

Dr. M. A. BOYD read a paper on Defective Metabolism in its Relation to Gout, in which he pointed out the interdependence of the great physiological systems on each other, and the probability of defective metabolism in any one of these systems being followed by derangements of the others. The defective metabolism that led to the formation of uric acid in excess was not confined to the digestive system alone,

but might originate also in either the circulatory, the nervous, or the lymphatic systems. Harbaczwski considers that the circulatory system contributes the chief share of this excess and has come to the conclusion that uric acid was the metabolic product of nuclein derived from leucocytes, grounding his conclusion on the increase of this acid in the blood and urine in leukæmia and pernicious anæmia. If this observer's conclusions be correct Dr. Boyd considered that the formation of uric acid must be intimately associated with both blood destruction and formation, and if uric acid is due to a leucolysis it must materially interfere with the contributory aid of the leucocytes in blood formation, and so account for the anæmia present in many of the forms of atonic gout.—Dr. WALTER SMITH agreed with Dr. Boyd in considering gout as a deeply-seated perversion of the nutrition of the body. Gout is coincident in many cases, but not in all, with the deposition of sodium biurate in certain tissues, especially connective tissue. The cause of the apparent or real accumulation of uric acid in gout is not known. The amount of uric acid varies within wide limits both in health and disease, and the causes of its variations are not known. The assumption that there is an increase of uric acid in a gouty person rests upon six experiments, five of which were made many years ago by a faulty process. There is no evidence to prove that uric acid is a poison analogous to an alkaloid. Dr. Smith agreed with Sir William Roberts in believing that the alleged acid dyscrasia in gout is no more than an assumption.

Dr. FINNY described an outbreak of Acute Dysentery which occurred in September, 1889, among the members of a family consisting of seven persons. Five were attacked, and two died—a female aged seventy years and an infant aged eleven months. The ages of the others were thirty-seven, forty-nine, and twelve years respectively. The first case began on September 12th, lasted fifteen days, and ended fatally. The second case occurred two days after the first, lasted fourteen days and terminated in recovery. The third patient fell ill on Sept. 19th and died in four days. The fourth patient fell ill also on Sept. 19th, and after nine days recovered; the fifth fell ill on Sept. 21st and recovered after seven days. No other inmate of the house (and there were several) was ill before, during, or after the outbreak, and no cause could be suspected except that for two days before the outbreak milk was used which had been supplied by a friend whose child was reported to have died on September 14th of intestinal disease. The family had just returned in perfect health from spending the summer at the seaside. It is probable that the latter cases contracted the disease by contagion. The treatment consisted of bread or arrowroot in boiled milk, chalk and opium, and for the pains laudanum enemata. Ipecacuanha in twenty-grain doses was given to two cases, but seemed to have no controlling effect, and the same may be said of every kind of astringent used. Recovery coincided with the passage of a formed fæcal motion. While discussing the treatment of dysentery Dr. Finny said that Mr. William Arthur Dickson, F.R.C.S.I., treated 183 consecutive cases without ipecacuanha and without a death in the Government Hospital of British Guiana during the year 1893.—Dr. LITTLE said that his experience in India was to the effect that the astringent treatment was not useful in India, but quite the reverse, and that the ipecacuanha treatment of virulent acute dysentery produced results unattainable by any other means. Vomiting after twenty-grain doses was very rare, unless in the first dose or unless opium was present as in pulv. ipecac. co. When pure and given in a little arrowroot ipecacuanha very seldom caused sickness. After the patient had an evacuation twenty minims of liquor opii sedativus in about two drachms of warm milk was injected with a small glass syringe into the rectum. If the patient had not a motion he was first given a warm water enema and subsequently the opium. In chronic dysentery he gave one grain dose each of ipecacuanha and extract of hyoscyamus in pill—from three to twelve being given in the day—and the patient put on a milk diet. At about the same time as Dr. Finny's cases occurred there were several cases in the Adelaide Hospital which presented all the symptoms of tropical dysentery, and the diagnosis was confirmed by post-mortem examination.

SECTION OF OBSTETRICS.

Tubal Pregnancy.—Suppuration of Ovary.—Exhibition of Specimens.

A MEETING of this section was held on March 6th, Dr. LOMBE ATTHILL, president, being in the chair.

Dr. ALFRED SMITH read notes of a case of Ruptured Tubal Pregnancy, with Hæmatocele of the opposite side, successfully operated on by him in St. Vincent's Hospital. The chief points of interest were the question of diagnosis and the pathological condition found during operation. There was no history of pregnancy; the menstruation was quite regular up to the very day when the patient was first seized with the abdominal pain and heavy menstrual flow. The pain was referred to the lower part of the abdomen, but was not so severe as to cause the patient to collapse; she was, in fact, able to walk to the hospital without assistance, although, on vaginal examination, nearly all the typical signs of ruptured tubal pregnancy were present. The condition on the right side was an example of "tubal abortion." The cyst on the left side was full of blood and had all the appearances of a tubal pregnancy, but the microscopic examination by Professor M'Weeney proved it to be an hæmatosalpinx.—Professor M'WEENEY said the dilatation on the left side resembled a case of tubal pregnancy. There were, however, a few points of difference: the walls in this case were thinner than they would be in a case of pregnancy, neither were they coated to the same extent with blood clot. If the contents consisted of clear serous fluid he (Professor M'Weeney) would have but little hesitation in describing the case as one of hydrocele. He found pus cells in the walls, from which he inferred that the tumour was inflammatory in its origin.—The PRESIDENT said that under any circumstances he would operate in a case of tubal pregnancy, and he mentioned the case of a woman who, after the lapse of twenty years, was expelling fœtal bones from her vagina.

The HONORARY SECRETARY read (for Dr. PUREFOY) a paper on a case of Suppuration in an Ovary the result of direct violence. The patient was twenty-one years of age, in good condition and of healthy aspect, and sought advice in February, 1895. The history of her illness was that in October, 1891, a child jumped on her as she lay in bed, causing her much pain in the left ovarian region and in the left leg. Immediately afterwards she became unwell for some days, and during the succeeding four years, till she came under Dr. Purefoy's care, menstruation continued profuse, irregular, and attended with so much pain in the lower abdomen and left leg that much impairment of her general health ensued. The uterus was enlarged and much retroverted, and the left ovary was enlarged, very sensitive to pressure, and somewhat prolapsed. The right ovary appeared to be normal and healthy. Removal of the left ovary was followed by an easy convalescence, and menstruation now recurs regularly without pain and is normal in amount, though for some months there was occasional severe pain in the left side and left leg.—The PRESIDENT regretted that they had not before them the report of a pathologist on Dr. Purefoy's case, as suppuration of the ovary was a very rare occurrence indeed.

Dr. JELLETT showed the following specimens for Dr. W. J. SMYLY:—(1) Four Myomatous Uteri removed by panhysterectomy; (2) a large Papillomatous Cyst removed from the right mesocolon; (3) Tubes Removed for Double Pyosalpinx and for Tuberculous Disease; (4) Hæmatosalpinx probably Originating in a Tubal Pregnancy, although no trace of an ovum had been discovered; and (5) Tubal Pregnancy Complicated with Gangrene of the Intestine six inches of which were removed, the canal being restored by Senn's bone plates. All these patients have either recovered or are progressing favourably

THE EPSOM WATER-SUPPLY.—The Epsom urban council is asking for powers to borrow £11,500 for works of water-supply—viz., the extension of the scheme which was set on foot two years ago, when a loan of £2500 was sanctioned to provide a new engine and boilers at the works. The present reservoir holds some 120,000 gallons, and it is proposed to erect a second on the Downs near the Derby Arms Inn. The site will cost £500, while an alternative site at Tattenham Corner would cost about twice that sum. The consulting engineer, Mr. George Hodson, said that a site in Langley Bottom, about a mile west of the Grand Stand, would be the best for the purpose if another reservoir were needed, but he was of opinion that the present water-works in East-street were free from pollution, and might properly be extended to the advantage of the ratepayers and on a more economical principle.

Reviews and Notices of Books.

Practical Studies in Fermentation. By EMIL CHR. HANSEN, Ph.D. Translated by ALEX. K. MILLER, Ph.D. London: E. and F. N. Spon. 1896.

TWELVE years ago Dr. Hansen of the Carlsberg Laboratory, Copenhagen, made an announcement of the greatest importance to the brewing industries. It has since led to important advances in other branches of industry, and it is hardly possible to estimate what will be the limits of further applications. We refer, of course, to Dr. Hansen's great discovery of a new analytical method and the certain demonstration that some of the commonest and most serious diseases of beer, such as yeast turbidity and objectionable changes in flavour, were caused, not by bacteria, but by certain species of yeast. This led to the elaboration of a method by which Dr. Hansen obtained pure cultures of systematically selected yeasts by a dilution method, with the result that the following important practical advantages in the brewing of beer were gained: 1. A definite result and rational working are secured where formerly everything depended more or less upon chance. 2. Maladies in the beer causing great losses are guarded against. 3. A yeast is obtained of higher commercial value than the ordinary impure yeast. 4 It places the industry upon a higher basis. The method did not, however, cease in its application to brewing. It has since been applied to other commercial processes. Pure cultures have been employed for the definite and wholesome souring of cream, for the manufacture of wine, cider, &c., and for the improvement of tobacco, which by inoculation prior to fermentation with bacteria occurring in Havanna and other superior kinds of tobacco may be made to acquire a superior aroma and a milder flavour. Dr. Hansen's book, admirably translated by Dr. Alex. Miller, is not, however, confined to the mere technique of industrial fermentative processes. It is, in addition, an important and interesting contribution to the life-history of micro-organisms. English readers have long heard of the remarkable researches and discoveries of Dr. Hansen, but have hitherto been debarred from reading in their own language the fascinating and historical sketch contained in the volume before us. A word of praise is therefore due to the translator for placing Dr. Hansen's "Untersuchungen aus der Praxis der Gärungsindustrie" before the English industrial and scientific public. Home manufacturers are notoriously conservative in connexion with the introduction of improved processes, but this is in a great measure due to ignorance and the absence of a clear conception of the advantages promised. We fear this ignorance is often wilful. Dr. Hansen's pure culture method, securing at all times a uniform product, has been adopted in almost all breweries on the Continent, but it does not seem to have found favour with the English brewers at present.

It is true of all branches of manufacture that with the advance of science mere traditional methods must be given up or the manufacturer will stand no chance in the race. It is the stolid indifference to the teachings of science which places the English manufacturer so far behind his Continental competitors. The discovery of Dr. Hansen is of immense promise and commences a new era in the engineering of organisms for commercial purposes, and home manufacturers and producers would do well to study it. We should like to see bacteriology made a compulsory subject in the curriculum of certain branches of the engineering profession. We might then hope for a satisfactory solution of some of our knottiest sanitary problems.

History of the Cholera Controversy, with Directions for the Treatment of the Disease. By Sir GEORGE JOHNSON, M.D. Lond., F.R.C.P., F.R.S. London: J. & A. Churchill. 1896. Price 3s.

IT is a significant fact that the history of the progress of medicine might be built up from a series of controversies. No important statement or observation has ever been allowed to pass unchallenged, and those who have had the temerity to attempt innovations have had to be supported by the courage of their opinions against the clamour of negation or of militant doubt which, in medicine at least, seems always to be aroused when the old landmarks are moved. It is a sign of the vitality of thought that such opposition has never yet daunted those who felt they had a message to deliver, and without a doubt the opposition has in very many cases led to further experiments and further observations which have been of considerable value in strengthening the views originally advanced. Controversies are never pleasant, but they may be useful, and when sufficient time has elapsed for the fierce heat of contest to have cooled to a large extent they afford much instruction and also much encouragement. Investigation almost invariably shows that any fact which is "now admitted nearly on all sides" has had to run the gauntlet and that its author, instead of being at once lauded to the skies, has had to endure the disappointment of a sceptical or inimical reception of his discovery. Hence sympathy is evoked and comfort is derived. The book before us contains the history of a controversy around the question of the treatment of cholera. Sir George Johnson tells why he was dissatisfied with the results of treatment with brandy and opium so far back as 1849, and how in 1854 he had good opportunity of testing the effect of castor oil in cholera and choleraic diarrhœa and of the storm of opposition excited by the publication of his cases. This opposition must have been the more discouraging inasmuch as it was partly carried on within the walls of King's College Hospital, where the new treatment had already given excellent results. Sir George Johnson gives a vivid account of the reception of his views, and all who read will agree with the critic who found reason to respect the author for the courage and zeal with which he enunciated doctrines which he knew to be unpopular. Instead of being crushed by the opposition he was roused to further efforts and he eagerly called to his aid new physiological and pathological data which supported his views, and he was rewarded in 1866 by making a convert of Sir Thomas Watson, the President of the Royal College of Physicians of London. Sir George Johnson quotes largely from the various reviews which were written at the time and he triumphantly points to the recommendation of castor oil in the instructions drawn up in 1892 by the Royal College of Physicians of London at the request of the Local Government Board. The position held by Sir George Johnson is clearly stated here and emphasised by italics: "*Opiates are useful to soothe irritation after the evacuation of the bowel: they are useless and even dangerous when the blood is poisoned or the bowel filled with morbid secretions.*" It is difficult to put down this little book without referring once more to the date (1854) of the author's successful trial of the eliminative treatment and congratulating him upon the results of his labours and upon the clear and temperate tone with which they are described.

LIBRARY TABLE.

Aids to the Analysis of Food and Drugs. By T. H. PEARMAIN and C. G. MOOR, M.A., F.C.S. London: Baillière, Tindall, and Cox. 1895.—New analytical methods have to be devised from time to time to keep pace with the exceeding subtlety of modern adulteration. The Society of Public Analysts are doing excellent work in this direction, and

their publication, the *Analyst*, is a valuable record of recent processes connected with the detection of the adulteration of food and drugs. The work before us appears to be, so far as we have examined it, an admirable little digest of the analytical work required at the hands of the public analyst. The processes described have been pronounced reliable by well-known analytical practitioners. Though a small volume it covers the ground involved in the analysis of food and drugs, and it will be referred to with advantage by those who are familiar with laboratory work.

Professor Roentgen's "X" Rays and their Application in the New Photography. By AUGUST DITTMAR. London: Whittaker and Co.—The publication of *brochures* on the subject of the new photography supplies a distinct want now that everybody desires to know all about it. The one before us is a popular exposition by Mr. August Dittmar. It is a fair and correct review of the history of the subject, but gives very few practical details likely to be of service to the aspiring "new photographer."

Food Adulteration and its Detection. By JOHN A. BOWER. London: Society for Promoting Christian Knowledge. 1895.—In this little work are described some simple methods for the detection of food adulteration adapted to the capacity and resources of him who while running may read. So far it is of distinct educational value. But the author is now and again apt to lead the reader astray when he conveys the idea in some cases that the detection of adulteration is a simple matter. The microscope, for example, is recommended as a means of detecting foreign fats in butter, while the reader is recommended to ascertain the melting point by observing the point at which the fat clears, without taking the very necessary precaution of decanting the fat from the curd and salt and of filtering it. We doubt whether the fat would ever get clear under these circumstances. In the chapter on tea and coffee he counsels his readers to beware of coffee essences. We have found some very excellent preparations in the market, as a reference to THE LANCET of July 7th, 1894, will show. Speaking of aerated waters, he says "they should contain carbonic acid gas, but may contain merely compressed air"! The book will eagerly be read by the amateur analyst, and it will be his fault if he fails to understand the simply and intelligibly written chapters.

Kelly's London Medical Directory, 1896. London: Kelly and Co., Limited. 1896. Price 6*s.* 6*d.*—Hardly any publishers are more widely known and appreciated than Messrs. Kelly and Co., to whom Londoners are indebted for the bulky and indispensable Post-office Directory. Their Medical Directory is a convenient and well-executed volume of a little over 500 pages, giving the names, addresses, qualifications, appointments, writings, &c., of the medical and dental practitioners, male and female, in London and its vicinity. The area thus included extends from Hounslow on the west to Barking on the east, and from Croydon on the south to Barnet on the north. The streets list is sub-divided according to the postal districts, a refinement which is scarcely necessary. Much information is given relative to medical schools, hospitals, medical and learned societies, and the medical staffs of various departments of the public service.

Medical Notes and Statistics of the British Expedition to Egypt in 1801. By W. T. BLACK, F.R.C.S. Edin. Edinburgh: Oliver and Boyd. Pp. 12.—Mr. W. T. Black has published in a pamphlet form the substance of a lecture delivered by him some years ago before the Medico-Chirurgical Society of Edinburgh, and although the slender *brochure* bristles somewhat formidably with statistics, it contains much interesting matter, general as well as medical. The subject of Mr. Black's paper is the British Expedition to Egypt in 1801, when, in the words of Lockhart, "the victories of Abercrombie destroyed a fatal prejudice which had of recent days gained ground that the military of Great Britain were unfit to cope with those of revolutionary France. Sir Ralph Abercrombie fell, mortally wounded, in the moment of victory before Alexandria; but his successor, General Hutchinson (afterwards Earl of Donoughmore), assisted by Sir David Baird in command of the troops from India, proved himself thoroughly competent to replace the leader who, according to the same authority, "had the glory of first leading English soldiers to victory over the self-styled invincibles of Bonaparte."

JOURNALS AND REVIEWS.

The *Journal of State Medicine*, March, 1896. Vol. IV., No. 2. Price 2*s.*—This number contains papers of considerable interest, and amongst them may be mentioned one by Professor Delepine on the desirability of legislature in connexion with tuberculosis of living domestic animals. The author insists more particularly on the insufficient appreciation in practice of the powers of the bacillus tuberculosis to maintain a saprophytic existence and of the great prevalence of the disease among domestic animals. Dr. Sydney Marsden's paper on Municipal Abattoirs and Meat Inspection, which he read at the Hull Congress of the British Institute of Public Health, is reproduced, as also is the discussion to which it gave rise. An abstract of Mr. F. W. Richardson's paper on the Bacteriology of Water is also given, and in it Mr. Richardson discusses in an interesting manner what value is to be attached to the bacillus coli communis as an index of sewage pollution. We are also glad to see that the first report of the Public Health Committee of the General Medical Council on the Examinations in Sanitary Science is reproduced.

The *Sanitary Record*. Vol. XVII., No. 327. Price 3*d.*—This number contains an article on the Diagnosis of Enteric Fever by Dr. E. F. Willoughby, in which he gives a concise account of the varieties of the disease which may be met with in practice; but it seems to us that Dr. Willoughby hardly attaches sufficient importance to the spleen as an aid in the diagnosis of the disease. The answers to the last examination papers for inspectors of nuisances are furnished in the number before us; they should prove useful to those intending to enter for examination. A paper on the Multifarious Duties of the Medical Officer of Health for Sunderland should serve to warn candidates for public health appointments as to what is expected of them by some sanitary authorities, and the remuneration they are likely to obtain for their services.

The *Veterinary Journal and Annals of Comparative Pathology* for March contains an article on Immunity and Heredity, by Mr. M. H. Hayes, F.R.C.V.S., which is interesting from the fact that it shows from what point of view the veterinarian considers this subject. A translation of an article on a Case of Multiple Extra-uterine Gestation, with Osseous Embolism of the Pulmonary Artery, by Victor Drouin (Alfort), and articles on Subcutaneous Emphysema and Surra are also of interest. In the editorial department a somewhat stringent criticism of the report of the Board of Agriculture by Major Tennant, Principal of the Animals' Department, is given, from which it will be seen that the veterinary profession is by no means satisfied with the present arrangement at the Board, and there certainly seems reason to find fault with an arrangement which places in the hands of men who have had little or no veterinary training work which can only be carried out satisfactorily by experts. A rather personal controversy on the question of the educational examination for the veterinary profession is printed, from which it would appear that the Council of the Royal College of Veterinary Surgeons is making strenuous and necessary attempts to raise the standard of the

general education of candidates for its diploma. An interesting case of Tetanus in the Horse cured with Antitoxin is given. In the April number of the same journal there appears a further article on Immunity, read before the Edinburgh Veterinary Medical Society, in which the old question, so long debated by Buchner and others, concerning the possibility of the bacillus subtilis being converted into the bacillus anthracis is again raised, but this time in the form of the following statement: "In all probability the bacillus subtilis may be converted into the bacillus anthracis, and our principal (Williams) is of a strong belief that this can take place in a manure heap." The evidence of such conversion, it is to be feared, is not of a very clean-cut kind. The portion of Mr. Walter Long's Agricultural Bill which excludes the landing of Canadian and foreign store cattle does not receive much favour in the eyes of Scotch cattle-feeders, and for this several good reasons are given. Accounts of the proceedings of the various medical associations and abstracts and extracts from foreign journals, some of them of considerable general as well as veterinary interest, complete an interesting number.

The *Phonographic Quarterly Review*. April, 1896. London: Sir Isaac Pitman and Sons—The present issue is of more than ordinary interest to the medical man skilled in deciphering the "mystic" outlines of phonography, inasmuch as no less than four articles are contributed by members of our profession. Dr. J. A. Gray, late physician to H.H. the Amir of Afghanistan, whose graphic pen recorded his impressions of the Court at Cabul in our columns a short while ago, leads off with a well-written article on "Afghanistan, its Ruler and his Work." In it he ably endeavours to prove that the Amir is not so black as he is often painted, and shows that in spite of his apparent cruelty the ruler of Afghanistan is more humane than many Englishman are apt to think. "Jottings in a South African Village," by Mr. Herbert Caiger, F.R.C.S. Eng., is topical just now, but independently of this fact the paper will be perused with interest. In "The Great Emotion" (fear) Dr. Gowers has a subject which in his hands should be, as it is, ably treated. The article on the "Ways of a Wanderer," by Dr. G. E. Morrison, is continued, the thread of the author's autobiographical reminiscences being broken to admit of an editorial account of his walk across Australia. Of the other articles, not one of which deserves to be passed over, we have only space to mention Thomas Allen Reed's review of "Spencer's Lucid Shorthand." It is not generally known that the father of Mr. Herbert Spencer invented a system of shorthand which the well-known philosopher learned and used when a boy of thirteen. The system belongs to the class of "joined vowels," but otherwise does not show any great merit.

MAGAZINES.

Science Progress.—The April number of this publication is devoted very much to the evolution of ideas. The first paper is by Captain Creak, R.N., F.R.S., on the General Bearings of Magnetic Observations, in which we are again reminded of the valuable contributions to science afforded by the expedition of the *Challenger*. Dr. Starling writes (Part II.) on Some Applications of the Theory of Osmotic Pressures to Physiological Problems, and Professor Bourne contributes the first part of an article on the Present Position of Cell Theory. Histologists will read with interest the paper by Mr. A. G. Tansley, B.A., who gives the first part of a dissertation on the Stellar Theory: a History and a Criticism. "Solid Solutions" is the terse and apparently paradoxical heading of a paper by Dr. James Walker, who, we believe, succeeded Professor Percy Frankland in the chair of Chemistry in University College, Dundee. If solutions are defined as homogeneous mixtures of substances in variable proportions the above heading is justifiable, since there are many mixed solids which fulfil the requirements of this definition.

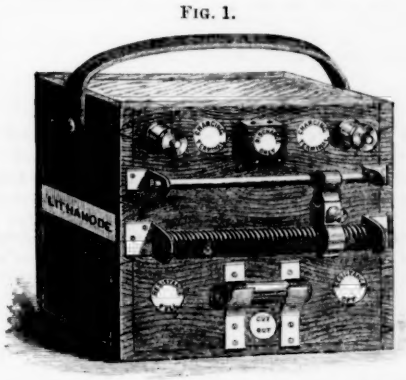
The Photogram.—This photographic monthly maintains its high artistic standard. It is printed on excellent paper and the reproduction of pictures is very well done. Considerable space is devoted to the "new photography," and the present number contains an excellent reproduction of a seven months' fœtus, which was the first complete human skeleton photographed by the new method. The original was by Professor Puluj of Prague.

New Inventions.

LITHANODE MEDICAL BATTERIES.

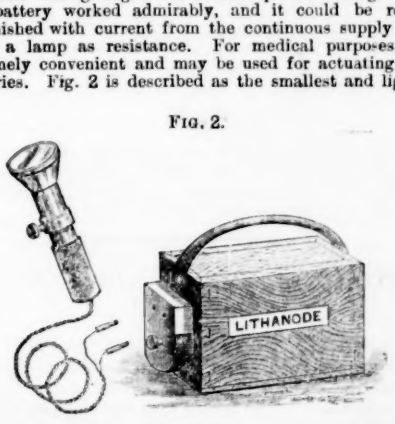
WE have recently had occasion to employ the Lithanode secondary batteries for working the induction coil for the new photography. For this purpose we have been using a two-cell 30-ampère hour battery identical with the battery shown in the illustration (Fig. 1), which is really constructed

FIG. 1.



for the purposes of an electro-cautery battery with a variable resistance capable of carrying current up to 20 ampères and fitted with a safety automatic cut-out. With an induction coil giving a three-inch spark discharge in air this battery worked admirably, and it could be readily replenished with current from the continuous supply main, using a lamp as resistance. For medical purposes it is extremely convenient and may be used for actuating large cauteries. Fig. 2 is described as the smallest and lightest

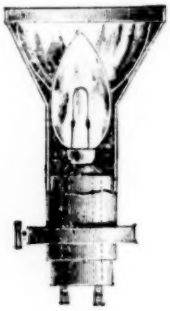
FIG. 2.



practicable secondary battery ever constructed, being 4¾ in. long, 2 in. wide, and 3⅜ in. deep, and weighing only 1½ lb. Despite these small dimensions and light weight this battery is capable of working the search light shown in Fig. 3, which gives a projected light of as much as 20-candle power for a period of fully half an hour with one charge. We find

that the discharge of these batteries is admirably uniform and steady. As the name of these batteries implies, the anode plates are of a peculiar construction which offers distinct advantages. There is practically no limit to the

FIG. 3.



size of the lithanode batteries, which are eminently suitable for electric lighting, cautery work, and for driving motors. They save infinite trouble and inconvenience, and the makers recharge them for a moderate sum. They are made by the Lithanode Electric Storage Co., Ltd., 3, Harvey's-buildings (opposite Coutts' Bank), Strand, W.C.

ANTISEPTIC LIGATURES IN TUBES.

MR. JOHN MILNE, of Ladywell, S.E., sends us a specimen tube of his most recent method of packing ligatures. The ligatures are twelve inches long and are carefully attached to a rigid frame enclosed in a glass tube filled with carbolic oil. The advantages claimed by Mr. Milne for these ligatures in straight lengths are that there is absolutely no waste; that each length comes out in a straight thread, there being no corkscrew curl as from a reel; that no handling to take out the curl is required, it being simply drawn out with the forceps; and that it cannot possibly get out of order like those on revolving reels.

THE ZEPHYRON.

THE "Zephyron" is an invention by which the slow combustion of various vegetable cigarettes, such as stramonium, lobelia, and many others, is effected by the exhaustive action of a jet of air. The instrument is made of vulcanite, and a

small elastic ball is used to produce the jet, which acts when the cigarette is lighted just beneath the part marked × in the diagram. The "Zephyron" is supplied by Messrs. Maw, Son, and Thompson of Aldersgate-street.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

A QUARTERLY meeting of the Council was held on the 9th inst., the President, Mr. CHRISTOPHER HEATH, being in the chair.

The Jacksonian Prize for the past year was awarded to the author of the dissertation bearing the device of a photograph of a microscopic specimen, and the quotation:

> "What are these, so withered and so wild in their attire,
> That look not like the inhabitants o' the earth,
> And yet are on 't?
> —*Macbeth, Act I., Sc. 3.*

The President opened the sealed envelope and announced that Mr. A. A. Kanthack, F.R.C.S. Eng., was the Jacksonian prizeman. The subject for the Jacksonian prize for 1897 will be "The Pathology, Diagnosis, and Treatment of the various Neoplasms met with in the Stomach, Small Intestine, Cæcum, and Colon."

The Walker Prize of £60 was awarded to Mr. Harold Jalland Stiles, M.B., C.M., F.R.C.S. Edin. The committee appointed by the Council in pursuance of the declaration of trust for the administration of the Walker Prize Fund reported that they had duly taken into consideration the work done in the United Kingdom and elsewhere, either partially or wholly within the five years ending on Dec. 31st, 1895, in connexion with the advancement of the knowledge of pathology and therapeutics of cancer, but it became evident that in any report to be presented to the Council much important work could not be considered, either because (1) it had not been done within the prescribed time limit; (2) it had no direct bearing on the treatment of cancer; or (3) it dealt with matters still under discussion and did not admit of its value being as yet estimated by direct observation or experiment. Of what remained after elimination had been made on the above grounds the work done by Mr. Stiles appeared to be the most worthy of the prize, on the ground that he has investigated most minutely the morbid anatomy of cancer, its mode of spread, its relation to the organ in which it originates, and its relation to the lymphatic system of the part. His work on the pathological anatomy of the female breast and its accessory portions appears to be specially valuable from the fact that he has been able to demonstrate, by his nitric acid method, that the mammary acini have a much wider distribution than has hitherto been described. The importance of this in the determination of the extent of operative procedure is of course very great.

It was resolved that the Rush Medical College, Chicago, should be added to the list of foreign institutions recognised by the Examining Board for the complete course of study required by the regulations.

The report of the Laboratories' Committee showed that since the 6th December 3290 specimens of diphtheria material have been examined and reported upon for the Metropolitan Asylums Board, and that the director has during the same period supplied 2389 doses of antitoxic serum for the treatment of diphtheria in the hospitals of the board. In addition to the number of doses sent out, about 2500 doses, each containing 1000 Behring's normal immunisation-units, have been set aside, principally to meet extra calls should they arise. Two papers have already been published in connexion with the grant from the Goldsmiths' Company. Dr. Sidney Martin, in a preliminary communication published August 24th, 1895, gives the results of the action of the diphtheria antitoxin in neutralising the effects of the ferment toxine and albumoses formed during an attack of diphtheria. Dr. Cartwright Wood, in a recent communication to the Royal Society,[1] gave the result of his experiments on the rapid production of active diphtheria antitoxin. This part of the investigation is extremely important from the large quantities of antitoxin now employed. At first, by the ordinary method, and after a considerable time antitoxic serum of the strength of about 50 immunisation-units per cubic centimetre of serum was obtained. As the result of Dr. Wood's investigation serum has been obtained in nine weeks 1 cubic centimetre of which contains 250 immunisation-units, and in one month Dr. Wood was able to obtain serum of a strength such that 1 cubic centimetre contains 125 immunisation-units. As 4 cubic centimetres will contain 1000 units, the practice of subcutaneous injection, especially in the case of children, is rendered much easier.

The President reported that he had appointed Mr. Reginald Harrison and Mr. John Langton as delegates of the College to attend the celebration of the twenty-fifth anniversary of the German Surgical Society at Berlin.

The Council resolved that £510 should be invested out of the College funds and should be kept apart as the Arris Bequest.

In answer to a letter received from the Midwives Registration Association the Council resolved that they were not prepared to appoint a representative on a deputation to the Government.

A letter was read from Miss M. Edith Durham offering to the College a portrait by herself in low relief (bronze) of her father, the late Mr. Arthur E. Durham. The gift was accepted with the best thanks of the Council.

The next meeting of the Council will take place on May 14th.

[1] THE LANCET, April 11th, 1896: A Preliminary Note on a Method for rapidly producing Diphtheria Antitoxins.

THE LANCET.

LONDON: SATURDAY, APRIL 18, 1896.

SHOULD the next International Medical Congress prove to be a failure it will not be for want of examples to imitate or errors to avoid. The three last in the series of which it will be the twelfth—that at Rome, that at Berlin, and that in London—were, taken in reverse order, so many object-lessons by which its organisers may be expected to profit—Rome as a warning, Berlin as a *succès d'estime*, London as a model.

Perhaps the place at which it is to be held may be the means of saving it from what proved so disastrous to its Roman predecessor—the excessive number of the *congressisti*. Moscow cannot attract so many participants in its proceedings as did Rome. So hampered were the organising committee of the last Congress by the sheer weight of numbers that confusion invaded every detail of its programme and the result was, in the language of one of its most conspicuous promoters, "un fiasco solenne"—a monumental failure. Apart from the fascinating interest of the City of the Cæsars the Italians themselves were not blameless for the overcrowding that made the Congress so unfavourably memorable. They were, by their own subsequent admission, possessed by the record-breaking spirit and longed to excel their Northern and Western brethren in the magnitude of their medical parliament. The consequences, fraught as they were with disappointment and even bitter feeling, are too fresh in the memory to need recapitulation. Sufficient to say, that its most authoritative members, representing the leading European nationalities, were at one in thinking with the Italian promoter already cited that "beyond all dispute the Roman Congress registered the apogee of international congresses," and that "from this period onward we may anticipate a steady decline in their magnitude."

As with the number of participants, so with that of the papers sent in for discussion—the tendency of future congresses must be in the direction of curtailment, of concentration, and of economy in time and attention. A well-considered agenda paper, restricting the number of communications and rejecting all but those of supreme and present importance, must be the guiding principle of the next programme; while the sifting process that must precede it need not necessarily exclude from publication in a summarised form the thousand and one papers or monographs that are sure to be sent in. The whole system of International Congresses, indeed, is on its trial, and it will rest with the organising committee at Moscow whether the Congress now in preparation is, or is not, to mark a new departure in such professional gatherings in which the convenience and comfort of the participants are to be duly consulted with a vigilant and effective regard to the interests of science and the furtherance of enlightened practice.

We could suggest no better course for the organising committee than a re-perusal and consideration of Professor MICHAEL FOSTER'S paper at the last Congress on the Organisation of Science. Recommendations not more sagacious than practical were advanced in that masterly address which are as applicable to medical congresses as to medical literature—recommendations of which the root-idea is the inter-communication of workers in the same branch of inquiry, the comparison of results already achieved, and the avoidance of repetition of experiments already performed and of the re-traversing of ground already trodden. Preliminary correspondence with the heads of the leading medical schools throughout the world would put the committee in a position to know what each was working at and thought desirable, and from this knowledge to construct a programme which should minimise the number of themes to be taken up and reduce it still further by the exclusion of all that was of inferior scientific or clinical importance. Some such course, in fact, will have to be adopted if anything like cosmos is to replace the chaos which was all too present at the Eleventh Congress held at Rome.

The organising committee has already exhibited a very commendable readiness to listen to any reasonable protest, and this spirit together with the sensible determination to keep special subjects within proper limits and to avoid the excessive sub-division into sections which characterised former congresses promise well for the success of the meeting at Moscow. We have already commented favourably[1] on this action, and in the same article we took occasion to refer to the difficulties that were likely to arise in regard to the "official" languages in which the discussions were to be carried on. It will be remembered that the languages originally selected by the committee were French, Russian, and German. We pointed out that the exclusion of English would have "the effect of deterring large numbers, not only of Englishmen, but also of Canadians, Americans, Australians, and others" from attending the Congress or from sending papers to be read at it. Our protest was received in the friendly spirit in which it was made, and on April 4th we were glad to be able to publish the substance of a letter written by Professor ERISMAN, the General Secretary of the next International Congress, to our St. Petersburg correspondent to inform him that the question of languages is to be reconsidered by the executive committee, and that in all probability the English language will be admitted to equal rights with German, Russian, and French, and that "this will be done because it has become clear that the exclusion of the English language would not be well received by our English colleagues, and the committee do not consider themselves justified in insisting on their first decision if the general opinion of our English colleagues is clearly against it. You may rest assured that the committee, in discussing this question and coming to their first decision, were guided solely by considerations of what would be of advantage to the Congress and were far from having in view the national aspect of the matter." As we have said above, the whole system of International Congresses is on its trial, but we see no reason, if the organising committee and the Russian authorities generally continue to act in the same

[1] THE LANCET, March 14th, 1896, p. 719.

wise spirit of consideration and courtesy, why the Twelfth Congress should not be as successful as any of its predecessors.

DR. BATCHELOR'S address as president of the Fourth Inter-colonial Medical Congress of Australasia, which was published in THE LANCET of April 4th, 1896, possesses in some respects more general interest than usually attaches to such utterances. The subject was the Present and Prospective Conditions of Medical Education and the address may fairly be presumed to be a typical representation of professional opinion in our Australasian colonies on this important question. Many of Dr. BATCHELOR'S remarks are, no doubt, of quite general application and in no way coloured by local considerations, but it is always interesting to see the trend of opinion in our colonies, whether that opinion follows, or is in advance of, the views prevailing at home. Dr. BATCHELOR is of opinion that the amount of general culture required of the student before entering upon his medical curriculum is altogether insufficient and that the recent great advances both in primary and secondary education in England and the colonies would justify a much higher matriculation test than that commonly required. In this matter the University of London has set a notable example which has had, and will still have, far-reaching consequences. After matriculation Dr. BATCHELOR thinks that there "should ensue two years of special scientific subjects preparatory to the strict professional education, which should continue for at least four years further." This would, of course, involve a six years' curriculum, a reform for which we are not yet prepared, but which no one can pronounce either absurd or incapable of realisation in the perhaps distant future. As regards the subjects which should engage the student's attention at the stage preceding the strictly professional curriculum Dr. BATCHELOR says rather happily that "the medical man of the immediate future should, above all things, aim at being scientific in his habits of thought and methods of practice. He should have acquired the eye of science, the ear of science, the hand of science, the judgment of science; he should know that he really sees what he is looking at, hears what he is listening for, and touches with discrimination what he handles." This is undoubtedly the correct ideal, but opinions will differ as to how it may be most surely and adequately attained. The general feeling at present is strongly in favour of the view that this preliminary training is best afforded by the physical and biological sciences. We are not sure that this view, just as it probably is in the main, is not at present somewhat overpressed. Medical men have to do much more than observe, and the capacities that might constitute an admirable botanist or zoologist might make a poor physician. It is probable that the value of literature, of general culture, of a knowledge of "the best that has been thought and done in the world," of psychology, &c., will be more and more recognised as time goes on.

Dr. BATCHELOR is very strongly of opinion that it would be of no advantage to return to the old method of apprenticeship. This method, he thinks, once had its advantages. In former days "most work was empirical and it was surely of some advantage to be associated with an empiric of great experience and possibly considerable success. So much depended upon observation of more or less transitory significance that, in the absence of scientific or theoretical principles the methods of actual practice were doubtless as good as might be got. However, I am inclined to think that if anyone still advocates the old apprenticeship plan as suitable to modern requirements, such a man has allowed the tide to run past him; he has failed to note the signs of the times and does not observe that exact science has advanced, is advancing, and will continue to advance in every department of our work and that the need for increased opportunities for scientific training becomes for our junior students more and more impressive." This is a just and most important distinction. The old system of apprenticeship, while possessing some undeniable advantages, was apt to turn out clever empirics rather than thoroughly equipped scientific practitioners. Dr. BATCHELOR speaks approvingly of the medical curriculum of the University of Sydney, according to which, it would appear, the first two years of the student's course are devoted to chemistry, physics, anatomy, physiology, and biology, in the third year materia medica and therapeutics are introduced, and it is not until the fourth year that the purely professional subjects are begun. However excellent this may appear on paper we must point out a practical difficulty which seems to us to be a real one. A student cannot postpone the commencement of his hospital training to his fourth year, and all clinical teachers will agree that there is great inconvenience in carrying on clinical teaching with students who have had no systematic instruction in medicine and surgery. Dr. BATCHELOR pleads very earnestly for a closer and more sympathetic relationship between universities and colleges on the one hand and teaching hospitals on the other. On this point there will be a general acquiescence in the views which he puts forth.

We publish in other columns an extended although necessarily not an exhaustive account of the proceedings of the Congress, and we take the opportunity of congratulating our brethren "down below" generally, and the practitioners of New Zealand in particular, on the great success which has attended what was evidently a very useful and very pleasant gathering of the members of our profession in Australasia. *Floreant.*

THE appeal of the Apothecaries' Hall of Ireland from the adverse judgment of the General Medical Council and its refusal to appoint examiners in surgery has an interest beyond that of the question immediately at issue. It is understood that the case between the society and the General Medical Council will be fixed for May, when the society will be represented by very able counsel and all that can be said in its favour will be advanced. Whatever the issue we cannot but regret that any such appeal should be necessary. The Medical Acts contemplate reference to the Privy Council in various emergencies. The Midwives Bill now before Parliament proposes to give a midwife whose name has been struck off the Register by the Midwives Board the right of appeal to the Privy Council. Could anything be more disproportionate or absurd? A practitioner removed

from the Medical Register has no such appeal. An appeal should be, if not easy, practicable and not far off; but an appeal from a midwife, say, in a provincial town, to the Privy Council is so impossible in aspect as to be tantamount to none. It is neither respectful to the midwife nor to the Privy Council. In plain terms it is ridiculous. It is creditable to the General Medical Council that this is the first time in its history that there has been an appeal from its judgment to that of the Privy Council. The General Medical Council is charged with the responsibility of representing the wisdom and justice of the whole profession in its relation to the public. There are two extremes of opinion which tend to bring about appeals to the Privy Council—that which regards the General Medical Council as existing only in the interest of the State and that which regards it as existing mainly to protect the interests of the profession. Both extremes are wrong. The General Medical Council is a domestic court to secure the efficiency and reputation of the medical profession partly through its corporations and other qualifying bodies and partly directly. Its powers are considerable, the more so as they are undefined. All who have the interest of the profession at heart will agree that the best thing for the profession is to have all questions arising under the Medical Acts settled in the General Medical Council. To have acted well nigh forty years without such an appeal being made to the Privy Council and also without any manifest disposition of the Privy Council to interfere with the action and freedom of the General Medical Council is some presumption that the latter body is capable of settling most questions. Those who think otherwise and who consider that some modification of its constitution is needed may well stay to consider the minimum of change required lest they compromise fatally the domesticity of the government of the profession.

Annotations.

"Ne quid nimis."

A CENTRAL BOARD FOR HOSPITALS.

THERE was a good meeting in the theatre of the Royal United Service Institution, Whitehall, on the 13th inst., to hear the scheme of the Charity Organisation Society, though many presumable supporters of the scheme were unable to be present. The scheme would give a place on the Board of 169 to about thirteen classes of representatives. The list of institutions or interests to be represented is a formidable one:—General hospitals, special hospitals, medical schools, provident dispensaries, other medical charities, medical corporations, the London County Council, the British Medical Association, the Hospital Sunday Fund, the Hospital Saturday Fund, the Charity Organisation Society, the City Parochial Foundation, and general practitioners. It requires a considerable stretch of imagination to suppose that charitable institutions maintained by voluntary subscriptions will consent to be controlled by bodies that do not subscribe to their maintenance and to which they owe no allegiance. Why should they invite the intrusion of the London County Council? or upon what theory is the British Medical Association to interfere? The best chance of success will lie in seeking, at least in the first instance, the coöperation of representatives of every existing charity that commands the respect of the public and of the Hospital Sunday and Saturday Funds. Mr. Sydney Holland is not far wrong in arguing that only some body that is supported by the power of the purse will have much controlling influence. The claim of the Charity Organisation Society to be represented may be disputed, but the hospitals would do well to recognise it. It may seem more critical than sympathetic sometimes, but its benevolence cannot be doubted, and hospitals would be stronger in public estimation for listening a little more to some of its criticisms. We repeat that a more modest beginning of a board should be attempted. Once established and worked, as Mr. Brudenell Carter suggests, "by advice, conciliation, and reasoning," it may do much good; it can easily be enlarged by the addition of the representative of any class or interest that gives substantial proof of its sympathy. This subject will be discussed by the Hospitals Association at the board room, Charing-cross Hospital, on Thursday, April 23rd, at 8 P.M. Lord Monkswell, a member of the Select Committee of the House of Lords on Hospitals, will preside, and important resolutions will be moved in favour of a reconstitution of the Distribution Committee of the Hospital Sunday Fund and of a central board of supervision.

THE NEW PHOTOGRAPHY: A STEP FORWARD.

WE have this week received information of a development in the new photographic process which promises to be of great importance in regard to its application to medicine. The improvement consists essentially in very materially reducing the exposure, so that in the case of hands and feet, &c. a few seconds suffice to give satisfactory detail. We have seen some good negatives so obtained with an exposure of less than twenty seconds. The process is occupying the attention of our laboratory department, but in the meantime it may be stated that the results are obtained by placing the negative (film side) upon powdered fluor-spar. It is evident in this case that the active rays are transmitted through the glass. The process gives promise of enabling us to obtain photographic images of objects within the human body with a comparatively short exposure, say five to ten minutes. The procedure would appear to be simple, and we hope many investigators will be induced to try it as it is in the direction of reduced exposure that progress is most needed to make Professor Roentgen's discovery of real value in medicine.

Mr. Nikola Tesla has made public the results of some of his experiments. He has worked, as might be expected, chiefly with the disruptive discharge coil commonly known by his name. He has obtained photographic impressions at distances of forty feet from the tube, and his first communication gives a large photograph of a person's back, showing the humerus and scapula. In the second letter he complains that the picture had suffered much in reproduction and that it ought to have shown clear indications of the ribs. He prefers a vacuum tube having one pole only; he insists that the higher the potential the greater the effect, and speaks of a luminous atmosphere as surrounding the vacuum tube while it is in action. From this and other points we are led to believe that he makes use of enormous potentials. In this country the Tesla coil has been regarded as less useful than the Ruhmkorff for "x" ray purposes, the powerful effect of the former upon the vacuum tubes being considered a disadvantage. Certain experimenters in London have obtained results from the use of a Tesla coil with the lamp attached to a single pole. Tesla's first paper, in the *American Electrical Review* of March 11th, is valuable because it describes the phenomena occurring in the vacuum tube, and enables an operator to see when the tube is

working at its best effect. He expresses the opinion that there is an actual passage of molecules from the interior of the tube to the outside, and thinks the sensitive plate is actually "bombarded" by these molecules; he also gives his reasons for this belief.

A JUDGE ON VACCINATION.

SIR WILLIAM GRANTHAM is chairman of the Barcombe parish council. Barcombe is a small village in Sussex—and at the close of the meeting of that body the other evening he took occasion to make a few remarks on vaccination, referring especially to the removal of the last assize from Gloucester to Cheltenham. A man who had been working in the assize court had, he said, been suffering from the disease of small-pox, and the Sheriff and Under-Sheriff consulted him as to the advisability of closing the public galleries. Holding this to be a serious step, he said he thought that it would be much better to remove the assize altogether, and as fortunately the city had no voice in the matter he, through the Lord Chancellor, obtained the necessary order of the Privy Council to take the assize to any place he might name, and he chose Cheltenham as the nearest place. To show that it was not from any personal fear, added Sir William Grantham, he went to Gloucester to try certain cases which had to be taken by a city jury, and also attended service in the cathedral. He referred to the protests of the anti-vaccinationists, and remarked that there were people in Gloucester who said boldly and publicly that they would rather see their children dead in their coffins than see them vaccinated. He was sorry to say they had been rewarded in the way they wanted; their children had died, but their conduct had created a spirit of lawlessness that perhaps they did not anticipate. Sir William Grantham went on to explain very lucidly the use of vaccine as a prophylactic, quoting extensive figures, and it is hardly necessary to state that the local and the executive anti-vaccinationist has come down like a wolf on the fold with an array of figures in opposition. Locally the speech has attracted much attention and some criticism, but his colleagues on the council passed a vote of thanks to Sir William Grantham for his useful speech.

IL CONTE MATTEI.

OUR Rome correspondent writes: Of the myriads of railway passengers who annually thread the many tunnels between Bologna and Florence how few are aware that not far from the station of Vergato stands the "Castello dei Miracoli," the picturesque abode of the most prosperous irregular practitioner of the nineteenth century. There it was that Count Mattei, scion of a rich and noble Genoese family, lived and laboured; there he received pilgrims for whom he was the embodiment of Bacon's "nobilis in villula lucubrans"—the patrician grappling with Nature in his château. There he sat as the central spider of a web whose ramifications extended all the world over and enmeshed patients of high and low degree, especially the former. Statesmen and diplomatists, men to whose judgment and finesse the most momentous as well as the most delicate missions were confided, had no hesitation in entrusting their health, mental and bodily, to a man who, according to his latest panegyrist, "studiò da se la medicina dopo avere scoperto il suo grande segreto" (studied medicine by himself after—note the order—after having discovered his great secret). And they were quite ready to show cause for the faith that was in them and one and all to assure their hearers that, having found orthodox medicine useless or worse, they had got rid of their ailment (whatever it was) and regained their powers of work and enjoyment of life by Count Mattei's "granellini di zucchero saturi di elettricità bianca, bleu, rossa, o verde" (sugar granules charged with white, blue, red, or green electricity), which were equally good for tubercle or chilblains, anæmia or plethora, cancer or wry-neck, acute melancholia or inhibitory paresis. The infallible logic of *post hoc, ergo propter hoc* was, in the case of these masters of statecraft, weapon sufficient to discomfit all sceptics as to the reality of their cure. Science and research demurred in vain to a remedy which was alleged to be equally efficacious in maladies not only contrary but antagonistic, while all the time, under the shelter of social prestige and aristocratic testimony, Count Mattei was not merely adding daily to his "miraculous cures" but steadily amassing a fortune which, in the language of the panegyrist aforesaid, "lo fece più volte millionario" (made him several times over a millionaire). Vainly did foreign custom-houses interpose their barrier to the import of his "granellini." Vainly was the law invoked against the sale of patent medicines the composition of which was undeclared even to the licensing authority. "Agents" were found not only to introduce the granules into every Christian country, but to effect their sale in quarters the most conspicuous and exposed, and the army of such functionaries, subsidised by Count Mattei at considerable cost, still left the gains from the "business" enormous. Dying the other day at Bologna he has bequeathed two million lire (£80,000) to charities, while the bulk of his fortune descends to his adopted son and heir, Mario Venturoli Mattei, to whom he has also left his "segreto miracoloso."

THE MANUFACTURE OF ARSENICAL SHEEP DIPS.

A FEW months ago some sensational revelations concerning the disastrous effects of the making of poisonous sheep dips on the operatives of certain East-end factories were published in an East-end paper. Assuming that these allegations had some foundation in fact we commented on the subject and emphasised the necessity of the Government taking instant measures to protect persons engaged in such an apparently dangerous employment. On the face of it it is reasonable to suppose that the preparation of a mixture containing nearly 20 per cent. of such a highly poisonous substance as white arsenic would be attended with some risk to health. We have, however, recently been convinced that it is quite possible to reduce the conditions of danger practically to *nil* by taking certain precautions in every stage of the manufacture. Our attention was directed to this fact by Messrs. William Cooper and Nephews, whose factory at Berkhamsted we recently inspected. We were much struck by the extremely healthy appearance of all those employed in and about the works. Most factory hands look pale and pasty, but all the men and boys we saw—and we visited all the shops—were ruddy, clean-skinned, and clear eyed. Sulphide of arsenic, which is to some extent formed during the course of manufacture, is very insoluble, and there is only one man in the place who has anything to do with the raw arsenious acid. He had been employed for thirty-three years, so that even working with the drug in a more easily assimilable form than the sulphide seemed to have had little or no effect upon him. This speaks volumes when we consider the fact also as some indication of the extent of the manufacture that the sale of this dip in 1895 was in excess of 1894 by over a million packets, representing an increased output of over 800 tons in one year. The only chance of risk appears to us to be involved not in the processes of actual manufacture in these particular works, but in the measuring out of the product into the cardboard packets. But in this department, also, every precaution that can be taken is adopted. The risk, however, attending this department will shortly be removed since we saw a highly ingenious piece of machinery being erected for the automatic measurement and for the packing of the powder. We record with

pleasure the care which is taken at these large and typical works to provide against injury to the workmen. We hope that the committee now sitting and inquiring into dangerous trades will compel similar precautionary measures to be adopted in all other factories where risks of the same kind exist. The application of arsenic for sheep dipping purposes would appear to require some care, but in the proportion that the arsenical compound is dissolved in water for the preparation of the dip it is quite safe. This is evident from the fact that 125 million sheep were dipped in a solution of the powder referred to without a single accident.

THE ARRIS AND GALE LECTURES.

IT appears that the lecturers paid by the Royal College of Surgeons of England out of the Arris and Gale bequests have hitherto only received the Gale portion of the remuneration. The Arris portion had by mistake become engulphed in the general coffers of the College. This is to be put right, and the sum of £510 is to be invested out of the College funds and set apart to fulfil the purposes of the bequest.

THE GENERAL HOSPITAL, ADELAIDE, SOUTH AUSTRALIA: A WARNING.

WE regret to learn from a telegram received on the 15th inst. by the President of the Medical Defence Union, that a very serious difficulty has arisen at Adelaide. The terms of the telegram are as follows: "Adelaide, April 15th, 1896. Government propose import paid men to replace Adelaide Hospital honorary staff, who have resigned in body under protest against Government action. Profession support them. Inform medical papers. Further particulars later." From the foregoing it is at least evident that no medical practitioner should accept any appointment to the Adelaide Hospital that may be offered him by the South Australian Government in the absence of the further information which has been promised. Immediately on receipt of this we will publish a statement of the causes which have led to this regrettable state of things.

EXTRAORDINARY TREATMENT OF AN EDINBURGH MEDICAL MAN.

A FEW weeks ago a paragraph appeared in the newspapers stating that, as the result of a post-mortem examination of a girl's body, an Edinburgh practitioner, Mr. G. M. Stocks, L.R.C.P., L.R.C.S. Edin., had been arrested on a charge of murder for performing an illegal operation from which death resulted. It appears that he was treated like a common felon, being taken from the court house to the prison handcuffed to pickpockets. After a time he was released on bail, and now he has been released altogether, the authorities having decided that there is no case against him. We hope next week to give the declaration made by Mr. Stocks to the Sheriff, from which it will be seen that a most extraordinary blunder has been made and that a hideous wrong has been done to an innocent member of the profession. The fact that the authorities have had to abandon all further proceedings is sufficient evidence of that fact. Unfortunately, there is no redress from Crown servants protected by privilege, and investigations conducted by the public prosecutor are made in private; but the profession is fully entitled to ask on what class of evidence was the warrant for the apprehension issued, or was it, as stated in the public press, the result of a post-mortem examination or the result of police inquiries? This point is, of course, one about which there ought to be no difficulty in ascertaining the truth. To the profession as a whole the case is of great importance and gravity, for it means that a medical man in the performance of his usual professional work may be suddenly arrested on the gravest of charges, and yet his arrest be due either to an opinion so erroneous or so distorted (in spite of a post-mortem examination) or to other evidence so flimsy that the charge collapses as soon as the competent authorities look into it. This cannot be regarded as a satisfactory possibility, and when it has been ascertained upon whose shoulders the blame rests it is to be hoped that steps may be taken to prevent the possibility of similar mistakes in the same quarter.

THE LONDON AND COUNTIES MEDICAL PROTECTION SOCIETY, LIMITED.

THE annual meeting of the London and Counties Medical Protection Society, Limited, will be held on Friday, May 1st, 1896, at the Restaurant Frascati, Oxford-street, London, at 5 P.M. The annual dinner of the Society will take place after the meeting at 7 P.M., under the presidency of Mr. Hutchinson, F.R.S. Medical men, not members of the Society, but interested in its work, are cordially invited to attend the dinner. Tickets, price 7*s.* 6*d.* each, exclusive of wine, may be had on application to the secretary, Dr. Hugh Woods, 11, Archway-road, Highgate, London, N.

THE RECENT CASE OF POISONING BY ANTITOXIC SERUM.

IT is perhaps one of the greatest tributes that the success of the antitoxic serum treatment could have paid to it that such widespread anxiety should be evinced at the recent case of alleged poisoning through its use that has occurred in Berlin. As yet it is not advisable to express any definite opinion on this case, but it may be well, whilst reserving judgment, to point out that the reports hitherto received and promptly transmitted to the public press are of a very vague and unsatisfactory character. First, it was stated that the child died several hours after the injection had been made; then news was sent that death took place within a few minutes of the injection. Now with the exception of the most virulent poisons death in such a short period is seldom brought about. In this instance it may be assumed that similar serum had been supplied for use on other patients, and had there been a poison virulent enough to cause the death of the patient in such a short time reports of other deaths must ere this have been received. It is satisfactory to learn that a careful analysis of the serum, which was sealed up immediately after this unfortunate occurrence, will be made, for there can be little doubt that this case will be made a centre around which will be grouped all the ill effects that follow the use of serum, whether *post hoc* or *propter hoc*, in any case of diphtheria.

THE RIGHTS OF THE SUBSCRIBER.

WE learn from a letter by Dr. Lediard, published recently in the *Carlisle Patriot*, that there is a proposal on foot to make some radical alterations in the voting powers of the subscribers to the Cumberland Infirmary. As matters now stand it is laid down by the statutes of this institution that: "Every subscriber of 2 guineas annually and every benefactor of 20 guineas shall have one vote at election of officers; every subscriber of 5 guineas annually and every benefactor of 50 guineas shall have two votes; every subscriber of 10 guineas or upwards annually and every benefactor of 100 guineas or upwards shall have three votes." It is now proposed that this elective power should be taken away from each individual subscriber and be put into the hands of a committee to be appointed triennially for the purpose. We must say that on the whole we sympathise with the proposed change and believe that in the end the institution in question would benefit by it. One objection

put forth against it is the possibility of a falling off in the number of subscriptions, the idea being that by having direct votes the subscribers feel they are "getting something for their money." We do not think the desire for votes will be likely to make much difference, besides which they will still have the privilege of electing their representatives on the committee. Looking at it from the honorary officers' point of view, we can only think the change would be a healthy one. Canvassing the county to obtain an honorary post on a hospital staff cannot but be a most objectionable proceeding to all concerned, and only naturally in such cases personal considerations are often apt to outweigh all others in the voting. By all means let each subscriber have a voice in the election of the committee, but the committee should do the electing. This would be a far less cumbersome method of proceeding than the one in vogue and one which should result in putting the right man in the right place.

MACCLESFIELD INFIRMARY.

MYSTERIOUS disappearances of important documents are a staple theme for elaboration by writers of fiction, and they occasionally occur in real life, with the result of producing much trouble and anxiety as well as sometimes a gratifying field of operations for the legal profession. The authorities of Macclesfield Infirmary are at present much perplexed by their inability to lay hands on the trust deed of the institution—an undesirable predicament for a public body to be in, although not likely to be attended by any awkward consequences. The honorary secretary has not seen the document since December, 1858, when it was completed and handed over to the residuary owner of the trust fund in the event of the trust relating to the infirmary failing from any cause. The gentleman into whose keeping it then passed had the custody of the documents and securities of Mr. Tunnicliffe, the founder of the infirmary, and he transferred the endowment fund to the Corporation of Macclesfield in compliance with the trust deed. The infirmary was opened in October, 1872, the proceedings were recorded in the *Macclesfield Courier and Herald* at the time, and the conductors of that prosperous journal have now the satisfaction of knowing that its columns contain the only available transcript of the missing document. It was supposed to be deposited in the safe of the Macclesfield Corporation, and the search for it appears to be conducted with such lack of zeal that when a meeting of the Documents Committee was summoned to investigate the matter only one gentleman was in attendance.

IMPROVEMENTS IN BRITISH BALNEOLOGICAL PRACTICE.

A SATISFACTORY feature in the recent history of British medicine has been the re-organisation of some of our most important spas and watering-places, and the serious attempt made to put this important department of practice on a scientific basis. Mr. Douglas Kerr's recent paper at the Balneological and Climatological Society draws attention afresh to this subject. Bath has in recent years quite renewed its ancient glory, while Harrogate, Buxton, and Droitwich—to mention a few out of many—are now among the best-equipped sanatoria in the world. Certain advantages, indeed, our continental rivals will continue to possess over us. No British resort can compete in point of climate with Carlsbad or Homburg or Vichy. In the matter of amusements also, especially in the provision of really high-class music, the continental spas are still superior to our own, though great progress has undoubtedly been made in this particular at the home resorts. It is well to remember that the patients who chiefly frequent these resorts are seldom complete invalids, that exercise in the fresh air is usually a cardinal principle of treatment, and that hence amusements of the right kind and of good quality are indispensable. The foreign resorts seem to excel in ingenious methods of applying the different waters. The Mont Dore methods are well known and are now imitated at several of the home resorts. The most recent innovation of this kind is the Nauheim treatment of chronic cardiac disease. The speakers at the recent discussion at the Balneological and Climatological Society seemed much divided regarding the methods of the new treatment. Mr. Holbeche of Malvern could not fully understand the *rationale* of the treatment. Dr. Snow thought the facts at present before the profession were insufficient to warrant any positive conclusion. Dr. Sunderland thought that the Nauheim treatment had been generally accepted on as slender evidence as the Koch cure for tuberculosis had been accepted a few years ago. Mr. Shirley Jones of Droitwich had tried the treatment with somewhat ambiguous results. It is evident that the Nauheim therapy is at present largely engaging the attention of the profession, and further information and evidence on the subject will be awaited with much interest. The facts hitherto educed, however striking and suggestive, have not been sufficient to carry general conviction.

THE RELATION OF DISEASES OF FOWLS TO DIPHTHERIA.

M. GALLEZ *fils*, who has been investigating the relation of diphtheria to the diseases of birds, has reported to the Belgian Academy of Medicine that there are two perfectly distinct diseases to which such birds as domestic fowls are subject. First, a contagious catarrh called also *morve* or "fowl glanders," characterised by a glairy secretion from the mucous membrane of the mouth, nostrils, and eyes, and also by rapid emaciation and paralysis of the legs. It is very contagious and very fatal, and may give rise to diphtheria in the human subject. Its primary cause is a bacillus similar to Löffler's, but far less virulent. If its virulence is artificially increased and a large dose injected into a dog or a guinea-pig, say ten cubic centimetres per kilogramme of the animal's weight, death rapidly ensues with symptoms precisely similar to those induced by Löffler's bacillus. When injected into fowls the so-called *morve* is reproduced. This disease differs from the second one, which is known as "fowl diphtheria," both in its symptoms and in its etiology, but has nothing corresponding to human diphtheria except its name. Experiments with antidiphtheritic serum showed that some curative effect was produced in fowls suffering from "contagious catarrh," though M. Gallez is unable to affirm that it acts as a certain specific. He explains the frequent immunity of persons handling fowls suffering from "contagious catarrh" to the comparatively slight virulence of the bacillus concerned as compared with that of the true Löffler's bacillus.

PEMPHIGUS.

DERMATOLOGISTS have generally regarded as typical cases of pemphigus that condition described by Duhring as dermatitis herpetiformis and also include under the same term urticaria papulo-bullosa, erythema multiforme, pustulous dermatitis, and hydroa. In the *Monatshefte für Praktische Dermatologie*, Band xxii., No. 6, is a short paper by Professor Petrini di Galatz of Bucharest. He comments on the various forms of skin disease which have been described under the term "pemphigus" and enumerates several in addition to those named above. He describes three varieties of pemphigus: (1) pemphigus vulgaris chronicus with periodic exacerbations and generally fatal termination; (2) pemphigus foliaceus; and (3) pemphigus vegetans vulgaris. The two latter forms may commence as a pemphigus vulgaris chronicus

(type 1), and then pass into either of the two other types. The last variety leads to a severe cachexia; it is the rarest of the three and the most dangerous. Closely resembling these three types of the disease is another condition which Professor Galatz draws attention to—namely, a group of "bullous dermatoses" which has been described as "pemphigus benignus," and which occurs in young subjects and is very apt to recur once or twice, but always ends in recovery. Bazin has described this same condition under the term of "hydroa bullosa," and it has sometimes been termed simply "hydroa," but it is not the same disease to which English dermatologists apply the term. But Professor Galatz thinks it very unadvisable to include under the term "pemphigus" bullous eruptions which in the course of two or three weeks quite disappear when the true pemphigus is such a serious and often fatal disease. According to his opinion pemphigus is the most serious of all dermatoses and yields the highest mortality, whilst "hydroa" (in the sense described above) is one of the least dangerous. The condition known as "pemphigus circinatus" he does not include as a true pemphigus, but includes it under the heading of Duhring's dermatitis, together with herpes iris, erythema iris, and erythema bullosum.

THE WATER-SUPPLY OF EGYPT.

IN his recent report Lord Cromer draws attention to a discovery which, he thinks, may revolutionise the whole question of the provincial water-supply in Egypt. In the opinion of our Consul-General in Egypt, "the importance of this discovery cannot be overrated. As the construction of filter-beds forms one of the heaviest items of expenditure in connexion with the water-supply of a town, and as it has been this particular initial outlay which has rendered the profits of these undertakings doubtful, it is evident that if a supply of pure water can be obtained by the comparatively cheap method described above it should not be difficult to attract capital into similar enterprises with a reasonable prospect of a return for the money sunk. As the geological formation of the Delta may be presumed not to vary greatly it is reasonable to suppose that the question of a good water-supply for the towns lying in this part of Egypt has been brought within the limits of practical solution." Borings recently undertaken at Tantah, in the centre of the Delta, prove that beneath the external alluvial deposit and the sand underlying it a second and apparently impermeable bed of clay exists at a depth of about 69 ft. from the surface. The thickness of this deep-seated bed is 6¾ ft., and as soon as the boring-tube pierced it water rose to within a yard of the ground level. The tube was then made to descend a further distance of 37 ft. through sand, the total depth attained being thus 106 ft. The supply of water is described as inexhaustible and apparently of the purest quality. Samples have been submitted for bacteriological examination to the Government expert, and if his report is favourable a firm of contractors is to be authorised to sink a well for the supply of the town. It has long been known that water could be obtained pretty nearly anywhere in Lower Egypt, provided the borings were carried deep enough, but apparently the idea of making use of it in the manner indicated by Lord Cromer never before occurred to anyone in authority. Some years ago the Royal Engineers took experimental soundings, so to speak, at Zagazig; and at Mena House, near the Giseh Pyramids, what has been called an artesian well exists furnishing an ample supply of extremely pure water. Specimens of the latter have been frequently analysed and pronounced to be practically identical with Nile water, and no doubt a similar result will attend the investigation now pending. That any water save Nile water should exist towards the sea end of the Nile valley appears to us extremely improbable. No doubt the water permeates the bed of the river at countless points in its downward course and then makes its way to the Delta beneath the impermeable clay stratum. If this explanation be correct there may be said to be two or more Niles constantly flowing seawards and superimposed one above the other. In this connexion we would draw the attention of the Egyptian authorities to the advisability of providing drainage for the removal, after fouling, of the water it is their intention to furnish. An unlimited supply of water in a town where there are no sewers is by no means an unmixed blessing. In an appendix to Lord Cromer's report Mr. Garstin insists on the necessity of drainage for agricultural purposes. The head of the irrigation department calls it "one of the most crying wants of Egypt at present," but to our minds the total absence of all drainage in the towns, from Cairo downwards, is a still more crying evil. In one case the increase of revenue is concerned, in the other the lives of thousands are at stake.

THE REPORT OF THE SANITARY COMMISSIONER WITH THE GOVERNMENT OF INDIA.

WE do not propose to deal with this voluminous and very able report on the present occasion, but we may nevertheless allude very briefly to the section devoted to the European Army of India during 1894. The year, we are told, having been a very wet one over the greater part of India, especially of Northern India, sickness increased, and influenza, cholera, and malarial fevers were more prevalent than in 1893. The strength of the European troops in the country was 71,082 in 1894; the admission-, constantly sick-, and death-rates were all higher than in the preceding year; the death rate was 16·07 per 1000, whereas in 1893 it was only 12·61. The chief causes of mortality were enteric fever, cholera, hepatic abscess, and injuries. Enteric fever caused 36 per cent. of the total deaths and cholera 13 per cent. Among the diseases which caused increased admission rates were influenza, cholera, enteric fever, ague, respiratory disease, dysentery, and venereal diseases — the latter caused no less than 34 per cent. of the total sickness and ague 26 per cent. In all the three presidencies venereal diseases and ague head the list of admissions into hospital. As regards mortality, however, enteric fever heads the list in all three presidencies, and in Bengal and Bombay the ratio was higher than the average of the decennium. We hope shortly to deal more fully with the report of the Sanitary Commissioner with the Government of India, but the foregoing figures will suffice to show the grave importance of the increasing prevalence of certain diseases among our troops serving in India.

CENTRAL CHANGES IN PERIPHERAL NEURITIS.

IN a recent number of the *Archives of Neurologie* Dr. Soukhanoff has an article on this subject, with special reference to a case of which he furnishes particulars. Until a short time ago peripheral neuritis was supposed to be a disease in which the lesion was confined to the peripheral nerves, but Kahler and Pick, Korsakow, Eichhorst, Campbell, and others have shown that changes also take place in the spinal cord, especially in the columns of Goll, although changes in the ganglion cells have also been described. Dr. Soukhanoff's case was that of a patient twenty-one years of age with a family history in which there were traces of a neurotic taint. He was of an amiable but somewhat weak character, often showed considerable energy, but never for very long at a time, was easily tired, and very impressionable. He developed a tendency to indulgence in alcohol, not a craving, but in his case sufficiently strong to lead to considerable over-indulgence. In 1892 he had an attack of delirium tremens and another in 1894. In

the latter he threw himself out of a second storey window. A few months before his admission to hospital he was noticed to walk feebly and he was much troubled with stomach derangement. He gradually became worse, and on his admission there were slight weakness of the right side of the face, nystagmus, feebleness of both arms but more of the right than of the left, the hands being weaker than the other parts of the limbs, and there was also weakness in both legs, but affecting the smaller muscles most. The knee-jerks were not obtained and there was tenderness on pressure. The memory was bad and there was considerable psychical change. Tubercle bacilli were present in his sputum and he gradually became more and more feeble, the immediate cause of death being the pulmonary condition. At the necropsy empyema and advanced phthisical processes were found in the lungs and parenchymatous neuritis in the peripheral nerves. But changes were also found in the cord, the columns of Goll in particular being degenerated throughout almost the whole extent of the cord.

THE CHEMISTRY OF THE POISONS OF DIPHTHERIA.

WE have noted in our report of the proceedings of the last meeting of the Council of the Royal College of Surgeons of England that Dr. Sidney Martin has laid before the College a preliminary report of the work done by him in connexion with this subject under the grant from the Goldsmiths' Company. It appears to us that Dr. Sidney Martin's work is very suggestive, and a further report in confirmation will be awaited with interest. He has ascertained that the antitoxin, when injected by itself, in no way interferes with the nutrition of the animal, the temperature remaining normal and the weight increasing steadily. When injected along with the ferment toxine it prevents any marked rise of temperature, allows the weight to rise, and if given in sufficient quantities prevents degenerative changes of the nerves and cardiac muscle, although, if the quantity of antitoxin be not sufficient, some slight degeneration of nerves is noticeable. When injected along with the albumose, which by itself causes marked fever with first a rise and then a fall of temperature, the febrile reaction is greatly modified. The temperature varies much less than when the albumose is given alone and rapidly returns to the normal. As regards alteration in weight—an important indication of the state of nutrition—the albumose alone appears somewhat to interfere with natural increase, though it seldom determines any diminution, but when it is mixed with antitoxin the weight of the animal steadily and rapidly increases. Albumose alone produces degeneration of both nerves and muscles, and its exhibition is frequently followed by paralysis; but when antitoxin is given along with it these conditions do not make their appearance. Dr. Martin is continuing his investigations. Two important points brought out by his recent experiments are: (1) that antitoxin, if properly prepared, is harmless when tested on animals; and (2) that in the case of patients suffering from severe diphtheria it is necessary to give much larger doses than in ordinary cases (4000 immunisation-units) in order to neutralise the action of ferment-toxines and albumoses.

A PAPER of great importance to sanitary authorities was read by Dr. John F. J. Sykes, medical officer of health of St. Pancras, before a meeting of the Sanitary Institute on Wednesday last. The almost hopeless tangle (caused by cross-references) in which the Factory and Workshop Acts are at present makes a *précis* of the Acts set out in logical order of the utmost value, and this Dr. Sykes attempted to do. We hope to print a summary of the paper in a future issue of THE LANCET.

THE Hunterian Society proposes, on Wednesday, April 22nd, at 8.30 P.M., at the London Institution, Finsbury-circus, to hold a discussion on Joint Affections in Nervous Diseases. Mr. Targett will read a short paper on the subject illustrated by lantern slides. Dr. Beevor, Dr. Buzzard, Dr. W. M. Ord, and Dr. Aldren Turner have promised to take part in the discussion. Visitors will be cordially welcomed, and any wishing to speak are requested to communicate with the senior honorary secretary, Dr. F. J. Smith, 4, Christopher-street, E.C.

WE have received from the Home Department a programme of the Second International Pharmaceutical Exhibition which has reached that department from Austria through the Foreign Office. The exhibition will be held in Prague from Aug. 15th to Sept. 15th, 1896, and the executive committee invites exhibitors. All communications should be made to the President of the Executive Committee, Dr. K. Fragner, Prague, who will give information in answer to inquiries.

A CONFERENCE on the subject of Irish Workhouse Reform is to be held at St. Martin's Town Hall, Charing-cross, on Wednesday, April 29th, at 3 P.M., at which Dr. Moorhead, honorary secretary of the Poor-law Medical Officers' Association, will speak, supported by other speakers conversant with the working of these institutions.

MR. REGINALD B. D. ACLAND'S annual address to the members of the Hospital Saturday Fund is issued in pamphlet form and published at the offices of the Fund, 59, Farringdon-road, E.C., at the modest price of 1*d*. It is worth a perusal by all who take an interest in the work of our hospitals.

LORD RUSSELL OF KILLOWEN presided on Tuesday night last at the Freemason's Tavern over the annual dinner in connexion with King's College Hospital. During the evening subscriptions and donations amounting to £3340 were announced towards the debt of £6000 under which the hospital lies.

COUNT DEYM, the Austro-Hungarian Ambassador, has promised to preside at the fifty-first anniversary dinner of the German Hospital, which will take place at the Whitehall Rooms on June 26th next.

SOUTH-WEST LONDON MEDICAL SOCIETY.—A meeting of this society was held at the Town Hall, Wandsworth, on the 8th inst. A paper was read by Dr. P. Cauldwell Smith, medical officer of health of Wandsworth, on the Vaccination Laws and their Amendment. A discussion, followed in which Dr. Morgan Dockrell, Mr. T. A. I. Howell, Dr. Gilbert Richardson, and Mr. W. G. Dickinson took part.

ÆSCULAPIUS LODGE.—The last meeting of this lodge for the Masonic year was held at the Café Royal, Regent-street, W., on Wednesday, the 8th inst. G. Crawford Thomson, M.D. Durh., the Master, presided. Thomas Dutton, M.D. Durh., M.R.C.P. Edin., was elected Master for the ensuing year; G. Danford Thomas, M.D. Brux., treasurer; and C. M. Simpson, M.R.C.S. Eng., and George Herschell, M.D. Lond., auditors. G. Rowell, F.R.C.S. Eng., was elected a joining member, and J. Campbell Maclean, M.B., C.M. Edin., and Thelwell Pike, M.D. St. And., were proposed as such. W. Stacey Colman, M.D., M.R.C.P. Lond., and C. Henson Broadhurst, L.R.C.P. Lond., were admitted to the second degree. The sum of 10 guineas was voted to charity. Other business being disposed of the lodge was closed. The members afterwards dined together, when the usual Royal and Masonic toasts were duly honoured.

THOMAS WAKLEY,

THE FOUNDER OF "THE LANCET."

A BIOGRAPHY.[1]

CHAPTER XVI.

Bransby Cooper v. *Wakley.—Sir James Scarlett's Address.—The Witnesses for the Plaintiff.—Wakley's Reply.—The Verdict.—The Results of the Trial.—The Solid Opposition to Wakley and his Solid Following.—The Attitude of the Public and the Profession.—Wakley's Expenses in the Trial Defrayed by Public Subscription.*

ON the morning of Saturday, Dec. 13th, 1828, before an immense and very excited audience, Sir James Scarlett rose to address the jury in behalf of the plaintiff, Mr. Bransby Cooper. His opening words betrayed his irritation at the position in which Lord Tenterden's decision of the previous day had placed him. He complained acrimoniously that his client, a gentleman seeking redress for one of the most injurious attacks upon fame and fortune that had ever been brought to the cognisance of a court of justice had been placed during an entire day upon his defence as though he were the defendant and the indictment a criminal charge. "I have no doubt," he said, turning to the jury, "that you are now sitting in judgment, not upon what reparation shall be made to an injured man for one of the basest calumnies any man could complain of, but whether Mr. Cooper is not a party unworthy of his situation, who has contributed to shorten a man's life." He then briefly sketched Mr. Bransby Cooper's honourable and successful career. This started with pupilage at the Norwich Hospital—a not irrelevant fact, for the ancient city was famous, in those days for its skilled lithotomists, vesical calculus being a common malady with the dwellers on the chalky soil of Norfolk. From Norfolk he came to Guy's Hospital, and on completion of his time there accepted a commission in the Royal Artillery and saw service on the Continent and in Canada for three years with credit to himself. In 1816, at the termination of the dispute with America, he left the army and after a short sojourn in Edinburgh returned to Guy's Hospital as apprentice to his uncle, Sir Astley Cooper. His apprenticeship expired in 1823, when he was made demonstrator of anatomy. In 1825 he was elected assistant surgeon to the hospital. From that time forward until the publication of the libel not a word had been said against him, and counsel ridiculed the idea that Sir Astley Cooper would ever have employed a man as his assistant or his deputy in the most important surgical practice in the world without being fully assured, nephew or no nephew, that he was a highly competent operator. He attributed Wakley's accusations of nepotism to an unbalanced sense of the importance of THE LANCET, which had arrogated to itself a position of censor of professional manners and morals. Sir James Scarlett then explained the operation of lithotomy, very lucidly considering that he was only able to employ lay terms, and dwelt on the difficulties that might arise in its course. Coming to the particular operation the performance of which formed the subject of the libel, he traversed most of the statements and all the insinuations contained in THE LANCET report. So far from the patient being a healthy countryman he was, said Sir James Scarlett, a stout man with a hectic complexion and disordered kidneys upon whom the operation was not performed until the agony that he suffered precluded any other course. The delay and the employment of the various instruments were due not to any error on Mr. Bransby Cooper's part but to the peculiar difficulties of the case and the awkward position of the calculus. The appearances in the cadaver were, he maintained, all of them in agreement with this view, save one rent in certain soft, easily lacerated tissues. This rent, it had been insinuated by THE LANCET reporter, had been made by Mr. Bransby Cooper's ill-directed attempts to reach the bladder with various instruments. It was, as a matter of fact to be proved by the oaths of persons who had examined the parts before the agent of THE LANCET had handled them, made by that agent himself after death. He denounced Mr. Lambert as a hireling, instigated by malice to write untruths, ignorant, and absolutely wanting in all decent feeling, as shown by the dramatic form into which he had cast his false report, and he wound up a vigorous piece of advocacy by asking the jury to mark their sense of indignation at the treatment that the plaintiff had received by awarding him exemplary damages. He then called Mr. Callaway, who had assisted Mr. Bransby Cooper in the performance of the operation.

Mr. Callaway testified to two things of importance—the first was that Mr. Bransby Cooper's original incision was rightly directed; the second was that the situation and shape of the stone were such as to make the extraction necessarily tedious and difficult. He confirmed THE LANCET report in many details, such as that numerous different instruments were used, that a second incision into the bladder had to be made, and that the operator during the operation did say that he could not explain the cause of the delay; and he admitted in cross-examination that in his opinion Mr. Bransby Cooper had no knowledge of the situation of the stone. Mr. Callaway was the only medical witness called by Sir James Scarlett who actually saw the operation upon which the alleged libel was founded. The other medical witnesses were called to testify to the general difficulty of the operation and to the high character of Mr. Bransby Cooper, whilst they added for the benefit of the court their expert opinion of what had happened founded upon Mr. Callaway's evidence.

Mr. C. Aston Key, senior surgeon to Guy's Hospital and Mr. Bransby Cooper's brother-in-law, came first; then Mr. Laundy, a general practitioner, who stated that he was present once at the same operation when it was performed by that celebrated surgeon and anatomist the elder Cline, on which occasion the proceedings lasted an hour and forty minutes. Mr. Brodie, afterwards Sir Benjamin Brodie, of St. George's Hospital, President of the Royal College of Surgeons of England and of the Royal Society; Mr. Benjamin Travers, surgeon to St. Thomas's Hospital, Mr. Joseph Henry Green, surgeon to the same institution, and Mr. Dalrymple, surgeon to the Norwich Hospital, considered that Mr. Callaway's evidence showed that the skill of the operator could not be impeached.

Dr. Hodgkin, lecturer on morbid anatomy at Guy's Hospital, gave important evidence. He thought that in the unfortunate patient there had been present an anatomical conformation of the parts as revealed by post-mortem examination that would have rendered the operation a difficult one. He swore that Mr. Lambert came to him and asked permission to see the parts, and was allowed to do so in his (Dr. Hodgkin's) absence. That on his return Mr. Lambert showed him a certain rent, the rent which it was insinuated in the report had been caused by Mr. Bransby Cooper's bungling. He at once taxed Mr. Lambert with having made the rent, it being his firm conviction that it had been made after death.

Last came Sir Astley Cooper. He confirmed the statements as to his nephew's honourable and successful career, and said that no one save the man actually operating could judge fairly of the difficulties of an operation. He gave as an

[1] Chapters I., II., III., IV., V., VI., VII., VIII., IX., X., XI., XII., XIII., XIV., and XV. were published in THE LANCET, Jan. 4th, 11th, 18th, and 25th, Feb. 1st, 8th, 15th, 22nd, and 29th, March 7th, 14th, 21st, and 28th, April 4th and 11th respectively.

explanation of the cause of the delay in the operation the fact that the bladder was empty and narrated a case in point where contraction of an empty bladder over a calculus had caused a skilful surgeon "now present in the court" to take an hour to effect the extraction.

This completed the plaintiff's case and Wakley rose immediately to reply. He said it was most remarkable that out of 200 persons present at the operation the plaintiff had thought proper to call only one—a solitary one—to give evidence to his skill on the occasion out of which the libel arose, whilst a host of persons who knew nothing at all of that operation were called to speak to his professional ability. This he characterised as an attempt to practise an imposition on the jury and on the public, but he hoped that the jury would not be persuaded by the general opinion of men not present at the operation that the specific facts spoken to by THE LANCET report did not occur. He pointed out that Sir James Scarlett had devoted a considerable part of his speech to miscalling Mr. Lambert THE LANCET reporter. Of course Mr. Lambert was a hireling, said Wakley. He was paid for his contributions to THE LANCET just as Sir James Scarlett was paid for the advocacy of Mr. Bransby Cooper. Wakley then cautioned the jury against the evidence of "a gang of hospital surgeons" only one of whom had seen with his own eyes the things to testify to the accuracy of which or otherwise they had been called. They stuck to Mr. Bransby Cooper because they knew that his case might some day be theirs. They had come there to bear down the weight of honest testimony by their names and influence. The question, he contended, was not the abstract one whether lithotomy was or was not a difficult operation, but the particular one, whether Mr. Bransby Cooper had performed a certain operation with due skill. He begged the jury to ask themselves whether they would be willing to employ the plaintiff as a surgeon if it were necessary for them to undergo this operation. And if they would not, he maintained that they must give a verdict which would prevent the plaintiff from returning to Guy's Hospital. He wound up an eloquent rather than a closely-reasoned speech by an impassioned appeal to the jury to consider the case of the poor in giving their verdict—the poor who were at the mercy of the hospital surgeon. For himself, he said, he cared nothing. He was willing to go to prison, and willing to give up THE LANCET if that were found to be the course that justice dictated, but unless the jury considered that Mr. Bransby Cooper had performed this operation properly the plaintiff must be denied a verdict.

At the conclusion of his speech, which elicited loud applause in court, Wakley was so overcome with excitement, fatigue, and heat that he had to be supported into an adjoining room.

Lord Tenterden then proceeded to sum up the case. He recapitulated the evidence for the jury and spoke severely of the manner in which the report had been drawn up for THE LANCET. If the jury thought that the defendant had proved the unskilfulness of the plaintiff they were bound to give him their verdict, but they must remember that unimpeachable evidence had been given by Mr. Bransby Cooper's witnesses to the facts that numerous instruments were sometimes required in the performance of a lithotomy, and that the operation had failed many times when undertaken by most skilful surgeons. He did not agree with the plaintiff's counsel that the damages awarded, if any, should register feelings of indignation; on the contrary, a verdict should mark cool and deliberate consideration of facts.

The jury were absent for two hours, and on their return to court delivered a verdict for the plaintiff, damages £100.

The results of the trial were not at first apparent. The verdict constituted a victory for both sides or neither. Wakley had to pay £100 in damages and nearly three times that amount in costs for having published a malicious libel. But Mr. Bransby Cooper's was a much worse plight. The sum awarded to him bore no sort of proportion, however distant, to the evil that had been said of him. Damages £100 for such an accusation! The verdict told its own tale. Most certainly the jury believed Wakley's main statement—that the plaintiff had been guilty of malpraxis. On no other ground whatever could they have let him off so cheaply, having regard to the things that he had printed. He had accused Mr. Bransby Cooper by inference of manslaughter, making no secret of his belief that the death of the patient was the direct outcome of the ignorance of the surgeon. Mr. Bransby Cooper was a man of thirty-five years of age, enjoying a good private practice and a honourable public position. The things that had been said of him were calculated to utterly ruin him. If proved true, his not inconsiderable scientific prestige together with his large and increasing income were both lost to him. Grave as the consequences would have been to Mr. Bransby Cooper if Wakley had obtained a verdict, heavy in due proportion should have been the damages when a verdict was given the other way. Yet of the £2000 demanded—a by no means exorbitant demand when the nature of the libel is considered—only £100 were awarded. The jury paltered. They wished to do their duty. They felt that Mr. Bransby Cooper did not shine as an operator and that the defendant had made out his justification; but they did not consider the libel a decent account of what had happened. So they marked a general disapproval of both sides by awarding to the plaintiff a barren victory.

The enormous interest taken in this case by the public as well as the profession made of it a landmark between the times when all sorts of abuses were rife and the times when the profession as a whole set itself, under Wakley's energetic direction, to work out its own salvation. As has already been said, when Wakley announced his intention of supplementing his reports of the lectures of hospital surgeons by accounts of the operative proceedings at different institutions he crossed the rubicon and declared war on the heads of the profession. They looked upon his action as one of intolerable aggression to be resisted in all conceivable ways. Skirmishes had since occurred in which the victory had lain now with one side and now with the other. Here and there Wakley's reporters had been turned out of the hospitals, while on several occasions Wakley had been able to print details of hospital management or treatment the reverse of creditable to those responsible for them, and to distribute nicknames, ridiculous yet adherent. But these were but skirmishes, while the case of Bransby Cooper *v.* Wakley was a pitched battle. Everything that it was possible to say fairly against Wakley's methods in issuing THE LANCET could be said in reference to this case. The evidences of personal ill-feeling against a certain group of distinguished men was not wanting in it, and its publication was bound to hold the profession up to the contempt of laymen. A solid feeling of anger among the hospital officials, medical and lay, was created by Wakley's line of defence, and the damages exacted from him were not sufficiently high to cause any compensating satisfaction. At no time in his career had the Editor of THE LANCET such bitter and organised opposition to meet as immediately after this sensational trial. His reporters were expelled from the learned societies, he himself was excluded from the walls of three or four of the largest metropolitan hospitals, and, lastly, the other medical papers of the day, such as they were, were supported by all Wakley's foes, the facilities denied to THE LANCET being given to its rivals. The partiality of this proceeding touched Wakley nearly; the rest concerned him not a whit, for the

offers to assist him with information were numerous almost to the point of constituting a nuisance. But the difference made between THE LANCET, the pioneer of reform, and its imitators galled him. He had the pride of a parent in his paper, and he did not like to see the bantlings of others favoured at the expense of his sturdy offspring, however natural the preference might be in those who showed it. Wakley had been called, and was still called, a thief for reporting hospital lectures, and a malicious slanderer or a panderer to morbid tastes for publishing hospital reports. In spite of all that had been said he had persevered in his ill-doing, believing it to be exceeding well-doing. But when the leaders of the profession saw that a measure of publicity was to be their fate, while not abating their animosity to THE LANCET they permitted the editors of other journals to do what they found in Wakley to be hideous crimes. This injustice he felt, and the feeling found vent in savage criticism of his contemporaries. They in their turn wrote in unspeakable terms of him, and the recriminatory passages, certain of which will have to be quoted in connexion with Wakley's actions against Dr. Macleod, the editor of the *Medical and Physical Journal*, and Dr. James Johnson, the editor of the *Medico-Chirurgical Review*, form amazing reading for these politer days.

But if Wakley had by this time created a solid opposition he had behind him a solid following. The case, which had given common cause for terror and affront to hospital officials, had justified the policy of THE LANCET and came as a verification of the most burning of its Editor's words to the profession at large and also to the public. Never had Wakley said anything in his declamations against the evils of nepotism and the ineptitude of hospital officials that approached in severity the words that *should* have been used concerning the operative procedures at St. Thomas's Hospital supposing Mr. Bransby Cooper had bungled as Wakley alleged. And that he had so bungled Wakley continued to declare, asserting that THE LANCET had been cast in damages simply because of the bad impression created by the form of Mr. Lambert's report. The profession at large and the public believed Wakley, and the solid opposition of the authorities converted him in their eyes into an ill-used man. A numerously attended public meeting was held at the Freemason's Tavern on the Tuesday following the verdict, at which the following resolutions were proposed:—

1. That the best interests of the medical profession and of the public are identified with the cause of medical reform, and that Mr. Wakley, as Editor of THE LANCET, having given the first impulse to that cause, and having subsequently advocated it with undeviating firmness and fidelity, is entitled to the cordial thanks and support of this meeting.

2. That the purposes for which the hospitals and infirmaries of the metropolis were founded, and that the views of the humane contributors to their funds are materially promoted by the weekly publication of reports detailing the medical and surgical treatment of the unfortunate patients, and that Mr. Wakley, having originated the practice of publishing hospital reports, has conferred important benefits on medical science and on the cause of humanity.

3. That the independent and imperial principles on which THE LANCET were first established have been preserved by Mr. Wakley at all risks; and that a subscription be opened for the purpose of defraying the expenses of the late action.

4. That in accordance with the feelings that this meeting has expressed Mr. Wakley be invited to attend a public dinner, and that a committee be nominated to arrange the same.

The first and third of these resolutions were carried by a very large majority—five dissentients only among 300 persons; the second and fourth were agreed to unanimously. In accordance with the third resolution a public subscription was opened, Wakley asking for £407 7*s.* 9*d.*, being £295 10*s.*, Mr. Bransby Cooper's costs, £100 his damages, and £12 17*s.* 9*d.*, the Sheriff's poundage.[1] The sum was immediately subscribed, and the books were closed when the required total was reached, while two or three belated subscriptions which the donors did not wish to have returned to them were forwarded to the widow of Mr. Bransby Cooper's late patient.

There is one very pleasant thing to relate as an appendix to this sad and even terrible passage in Wakley's life. In after years he met Mr. Bransby Cooper and a formal reconciliation took place between them.

(To be continued.)

MIDWIVES BILLS.

IT is said that the second reading of the Midwives Bill is fixed for May 6th. It needs little political knowledge to say that in the present aspect of politics the chance of legislation on this subject is the very smallest, unless some disposition to agree with each other be shown among the advocates of such legislation. For we have no longer to deal with one Bill, but with several; they are becoming numerous and difficult to count. There is the Bill already before Parliament, ostensibly the old Bill, with the provisions of which we are all pretty familiar, but with alterations that do not seem to us improvements. There are the various changes recommended by the General Medical Council when this Bill was referred to it last year by the Government. Next comes the Bill of the Parliamentary Committee of the British Medical Association. Then the Lancashire and Cheshire Branch of the British Medical Association have properly applied their critical faculty to the Bill of the Parliamentary Committee and produced a complete Bill of their own. Possibly the Parliamentary Committee and the Lancashire and Cheshire Branch may come to terms with each other and produce a single Bill that will satisfy both the Committee and the Branch. Then there is the outline of "A Bill for the Prevention of Puerperal Fever" by Dr. W. Fraser, which will be found in THE LANCET of Feb. 29th. There is yet another document emanating from 143 gentlemen, including Dr. Rentoul, who are opposed to the registration of midwives in the way hitherto proposed in Parliament, but who realise the gravity of puerperal mortality and who "are anxious to improve the education of midwifery nurses and, if need be, to support a practical scheme of local registration. They do not object to the registration of midwives provided they act as midwifery nurses *only*, under the immediate supervision of medical practitioners, and are registered as midwifery nurses *only*. Nor do they object to such proposed legislation as would protect any of the present privileges of existing midwives." Here there are no less than six more or less distinct proposals for the purpose recognised by all parties of protecting lying-in women of the poorer classes from the mischief and the mortality that attach to the practice of ignorant and untrained midwives.

The Bill now before Parliament is ostensibly what has been hitherto known as the Midwives Bill, with clauses for the registration of existing midwives and of women who have had a certain amount of training and passed an examination under rules framed by a Midwives Board created by the Bill and approved by the General Medical Council. We say this is ostensibly the old Bill. But it differs and does not differ for the better. We miss in it the explicit limitation of the midwife to natural labour. And it is noticeable that nearly all the suggestions of the General Medical Council for its amendment are not adopted. This is a very remarkable circumstance, which throws a great responsibility on its promoters. The General Medical Council suggested the substitution of the title of midwifery nurse for that of midwife. This is not adopted.

[1] It will be seen that the correct addition of these sums amounts to £408 7*s.* 9*d.*, but by an oversight one pound too little was asked for.

The definition of the term midwife as one who undertakes to attend "cases of natural labour" is not adopted, and the clause dealing with the privileges of midwives is greatly altered from the similar clause in the previous Bills of the sort and is remarkable for not specifying, as the former Bill did, that in the certificate to be given under the Act the woman shall be restricted to cases of natural labour only. It is quite true that under Clause 12, Sub-clause 5, the omission to send for a medical practitioner where the case is not one of natural labour is regarded as a form of misconduct for which the midwife may be removed by the Midwifery Board from the Midwives Register. But the limitation should be clearly defined in a separate and early clause, as in the first Bills of the sort. We cannot notice all the points in which the promoters of the Bill have failed to accept the suggestions of the General Medical Council, but we must specify another. The General Medical Council expressed a decided opinion that existing midwives, as one of the conditions of registration, should produce some evidence of character and capacity. This condition does not appear in the wide clause for registering existing midwives in the present Bill. Surely, too, it is somewhat absurd to give a midwife who is dissatisfied with the penal action of the Midwifery Board the right of appeal to the Privy Council—a right which medical men do not possess under the Medical Acts.

The Bill of the Parliamentary Committee and that of the Lancashire and Cheshire Branch may be considered together. But they differ materially. The former follows the line of the old Midwives Bills, only substituting the title midwifery nurse for that of midwife, and clearly limiting the function of such persons to cases of natural labour. It penalises the use of the titles "midwifery nurse or midwife," or any word implying registration under the Act by those not registered. In addition—and this is the chief difference—the Bill of the Lancashire and Cheshire Branch, in a new section, penalises to the extent of £5 unregistered persons who, after a certain interval, "habitually for gain" attend women in labour, always and properly excepting those attending a woman during labour in a case of emergency. It is difficult to see how "women and newly-born infants are to be protected from the practice of midwifery—nursing by ignorant and untrained persons"—the purpose set forth in the preamble of the Bill of the Lancashire and Cheshire Branch—if some such prohibition is not made clear. But it must be made equally clear that no terror is contained in the Act for kind people acting in emergencies and in remote places. One of the most important features of the Bill of the Lancashire and Cheshire Branch is its large definition of the word midwifery nurse: it is said to mean, "A woman who attends cases of natural labour, *and afterwards tends the mother and child during the lying-in period under such rules, regulations, and medical control or supervision as may be from time to time laid down by the Midwifery Nurses' Board.*" Both Bills create a Midwifery Nurses' Board, to be appointed by the General Medical Council. In the Midwives Bill such a board is to consist of 12 registered practitioners, 3 appointed by the Royal College of Physicians, by the Royal College of Surgeons, and by the Apothecaries respectively, 3 by the Incorporated Midwives Institute, and 3 by the Lord President of the Council, 1 of whom, at least, shall be a woman. The Parliamentary Bills Committee requires the General Medical Council to appoint a Midwifery Nurses' Board of 12. The Lancashire and Cheshire Branch provides that the General Medical Council shall appoint the board to consist of 29 registered medical practitioners to be distributed as follows: for London and southern counties, 7 representatives; Birmingham, midland, and eastern counties, 5; Lancashire, Cheshire, Westmorland, and Cumberland, 6; Northumberland, Durham, and Yorkshire, 6; Wales and counties of the west of England, 5. The duties of the board are to frame rules of course of study, prescribe the subjects to be studied and the general standard, to frame rules for regulating the practice of midwifery nurses, all subject to the approval of the General Medical Council. The Bill of the Lancashire and Cheshire Branch in several additional sub-clauses defines the powers of the board. The Bill of the Parliamentary Committee strangely makes erasure from the register of a midwifery nurse "for infamous conduct" the act of the General Medical Council. That of the branch empowers the Midwifery Nurses' Board to appoint a committee or committees of not less than 3 to investigate charges, and gives to such committee or committees the power of erasure. The Bills are not explicit as to places of meeting, examination, &c. Both Bills, for reasons which it is difficult to understand, make the General Medical Council responsible for the register of midwifery nurses and for its publication In the Bill before Parliament it is one of the duties of the Midwifery Nurses' Board to establish and keep the register. It is obviously important that each locality should have an easy way of knowing whether its midwives or midwifery nurses are registered. The Bill now before the House provides that one copy free of charge be sent to each county council. In the Bill of the Parliamentary Committee it is provided that each medical officer of health be supplied with a copy. The Bill of the Lancashire and Cheshire Branch requires such a copy to be sent to the clerk of the local sanitary authority. Dr. Rentoul and those who agree with him would support a local registration of midwifery nurses We can only notice one point more in these Bills—that of fees. It is obvious that this system, however humble or local, cannot be worked without fees. The Bill before the House fixes the fee to be paid by women for examination at 2 guineas. The Bill of the Parliamentary Bills Committee and that of the Lancashire and Cheshire Branch leave the sum to be fixed by the Midwifery Nurses' Board. They provide that all moneys should be paid to the General Medical Council and all expenses be paid by that body. The branch thoughtfully adds that in case of any deficit arising it shall be paid out of Her Majesty's Treasury.

It remains only to notice shortly a contribution to the discussion of this subject in THE LANCET of Feb. 29th, 1896, by Dr. W. Fraser, entitled, "Suggested Outline of an Act for the Prevention of Puerperal Fever." Therein it is proposed that the medical officer of health shall keep a register of midwives. After twelve months no midwife is to be placed on the register without a certificate satisfactory to the General Medical Council, and no medical practitioner is to take a pupil or give a certificate unless sanctioned by the General Medical Council. The Local Government Board is to issue directions to midwives. The medical officer of health may prevent any woman attending cases for a period not exceeding six months. Appeal lies to the medical officer of the county. The medical officer of health is to make full inquiry into all puerperal deaths from sepsis in his district. The medical officer of health may prohibit any midwife or other person engaged in nursing from practising for two months under a penalty of not more than £20. Every medical officer of health may inspect the residences of midwives. A record of those midwives habitually receiving pregnant women into their houses is to be kept The record and the house shall be open to the inspection of the medical officer of health. Every registered practitioner may report a midwife to the medical officer of health or to her examining board for any breach of instructions supplied by the Local Government Board. Every registered midwife shall have power of recovery of charges for attendance as a midwife nurse. Every medical officer of health may warn unregistered persons assuming titles or practising midwifery. Should the offender disregard the warning she will be liable to a penalty of not more than £20. Medical practitioners are to notify still-births to the medical officer of health and to receive a fee of 2*s.* 6*d.* Any person interring, or certifying for the interment of, still-births without the authority of the medical officer of health is to be liable to a fine of £10. Sanitary authorities are to pay medical officers of health for their trouble under this Bill.

DR. DE BOSSY OF HAVRE, stated to be the oldest medical man in France, celebrated his 104th birthday on Good Friday.

ROYAL METEOROLOGICAL SOCIETY.—The monthly meeting of this society was held on Wednesday evening, the 15th inst., at the Institution of Civil Engineers, Westminster, Mr. E. Mawley, President, in the chair. Mr. E. D. Fridlander, B.Sc., gave an account of some observations of the amount of dust in the atmosphere made at various places during a voyage round the world in 1894–95. Not only did dust occur in the air of inhabited countries, over the water surfaces immediately adjoining them, and up to an altitude of 6000 or 7000 ft. among the Alps, but it was also found in the open ocean, and that so far away from any land as to preclude the possibility of artificial pollution, and its existence has been directly demonstrated at a height of more than 13,000 ft.

THE HISTORY, METHODS, EXPENDITURE, AND POLICY OF THE CIVIL RIGHTS DEFENCE COMMITTEE.

(*Continued from page 576.*)

IN THE LANCET of Feb. 29th we gave a summary of the objects and aims of the Civil Rights Defence Committee, and we now proceed to afford some further particulars concerning its origin and operations.

When Mr. R. B. Anderson was illegally imprisoned in Trinidad Mr. Conrad F. Stottmeyer, one of the oldest and most respected inhabitants and subsequently Mr. Anderson's surety, Mr. Toppin, and Mr. Wayman consented to act as trustees to a fund to be called the Civil Rights Defence Fund, to enable Mr. Anderson to proceed to England to lay the grievances of the colony before the public and to seek redress for his own wrongs. In all about £150 were subscribed, and out of this advances of 7*s.* a day were made to Mr. Anderson during the greater part of three and a half months he was kept under an excessive and illegal bail of £1000 to enable him to live to come to England. When this allowance was discontinued Mr. Anderson visited Barbadoes, a colony enjoying the advantage of representative institutions, which the colonists, being a spirited and independently minded people, have most jealously guarded ever since the colonisation during the Civil War in the seventeenth century. There he stayed for about six weeks, and was instrumental in founding at a public meeting the West Indian Civil Rights Defence Association, since called the West Indian Union, with branches in other West Indian colonies, and its monthly journal, the *Civil Rights Guardian*.

Coming to England well provided with introductions, credentials, and sworn evidence, Mr. Anderson obtained a hearing in many quarters, and his friends being impressed with the gravity of the grievances and oppression of a British colony including his own, constituted themselves into a society under the name of the British and West Indian Alliance, to take up and investigate, on the part of the people of this country, the complaints of the West Indies, and to coöperate with, and act in England for, the West Indian Union in all cases approved by the Alliance. On Sept. 4th, 1891, Mr. Anderson delivered at St. James's Hall, before the Balloon Society of Great Britain, a lecture entitled "A Plea for the West Indies," and this secured useful support. He obtained interviews with the British Foreign Anti-Slavery Society and the Aborigines' Protection Society, and won their acquiescence at least. Mr. Anderson also obtained an interview of three-quarters of an hour with one of the permanent secretaries and one of an hour with Lord Knutsford, the Secretary of State for the Colonies, but these interviews resulted only in the usual official *non possumus*. Subsequently the Alliance held a meeting at St. James's Hall and another at Southport. Meanwhile, Mr. Anderson had commenced his action against the three Trinidad judges, and had obtained from Sir Francis Jeune special leave to serve the writ on Sir John Gorrie in Trinidad out of the jurisdiction, and he succeeded also in serving Mr. Cook and Mr. Lumb in England, just catching the latter on board ship at Southampton as he was leaving for Trinidad. On this a motion was made in the Legislative Council in Trinidad for an inquiry into the judicial administration, and was carried by a majority of six to two of the unofficial members, the officials being permitted to abstain from voting. The application for inquiry was backed up by strong representations to Lord Knutsford and to the Prime Minister, Lord Salisbury, on the part of the Council of the West Indian Alliance. Lord Knutsford made some concessions and Sir W. Markby and Sir F. Pollock were sent out as a Royal Commission to investigate the complaints which had been made. A Committee of the Legislative Council of Trinidad and Tobago was applied to to conduct the prosecution of the charges. This prosecuting Committee in Trinidad telegraphed to Mr. Anderson to come out and to give evidence in Trinidad and to conduct the prosecution for them in Tobago and remitted the money to enable him to do so. It so happened that in the action against the Trinidad judges which Mr. Anderson instituted in September, 1891, in the Court of Queen's Bench, and which he had been conducting quite independently of the Alliance and the funds provided by Trinidad, a stay of proceedings had been obtained by the defendants in order that they might be placed in possession of the particulars of the damages sustained by Mr. Anderson for which they had asked. This lull enabled Mr. Anderson to proceed to Trinidad and give his evidence, but the Commissioners did not go to Tobago. The result of the inquiry was the amotion of Mr. Cook from office and the interdiction of Sir John Gorrie pending charges being brought against him. Prior to returning home Mr. Anderson visited several of the West India islands, holding meetings to strengthen the branches of the Union and establish others. After his return he laid his case before the British and West India Alliance, and its Council warmly espoused it. A deputation, consisting of General Graham, Mr. T. Shepherd Little, M.P., the Hon. Stuart Erskine, and other gentlemen, waited on the Council of the British Medical Association, which had previously gone fully into the details of the case, and now, Jan. 11th, 1893, in response to the deputation, adopted a resolution authorising the editor of their journal to publish Mr. Anderson's case for his benefit amongst the members of the Association, and the Parliamentary Bills Committee to do what they could to further the steps which he was taking in his application to the Privy Council. In this way a subscription was promoted and about £42 were raised, enabling the initial steps of the appeals to the Privy Council to be taken. That the response in a case involving professional rights so important and individual wrongs so unprecedented was not more general was probably due to the fact that the importance of defending these rights and redressing these wrongs did not come home to the profession in England until later, when the judgment of the Court of Appeal made Mr. Anderson's wrongs without remedy, and showed that medical men are absolutely at the mercy of all judges of record both for the recovery of their charges and their own personal safety. Besides this, amongst a certain section of the profession there is a mistaken repugnance to claiming the right to be paid for their services, although Mr. Anderson had claimed it in a way the least harsh and exacting that could be devised and under circumstances which compelled him to do it or be cheated with his eyes open—an example which would have been contagious in a colony like Tobago. Moreover, the course which Mr. Anderson had taken to compel the Colonial Office to investigate the Trinidad scandal was very much resented by the Department, and without being able to trace the source of the scandals Mr. Anderson found that a report was being widely circulated both within and outside the profession that he was a mischievous, cantankerous, meddlesome agitator. Added to this the wrongs which he had endured were so outrageous as to seem almost incredible to all who had not some insight into the matter, to prevent people from investigating the case and to lead them to conclude that some defect in Mr. Anderson's conduct had been a prime factor in the case, instead of his indomitable courage enabling him to survive an ordeal to which others had been induced to succumb. Thus the very iniquity of the wrongs done to him seemed likely to deprive him of all hope of redress.

The first and strongest accession of help brought by the investigation carried out by the Commissioners was that of Bishop Mitchison, formerly Bishop of Antigua, in the Leeward Islands, who wrote that "after reading the damning report of the Royal Commission he could no longer abstain from taking part with the Alliance in the movement." About this time Mr. Anderson was in his worst and greatest difficulty. His own relatives did all in their power to help him; an aunt, now in declining years, sacrificed nearly her all, and other friends who could ill spare it have assisted him to the best of their ability. His pension of £50 goes to support his wife and family in Tobago, and all that he has has been devoted to his immediate necessities. At this juncture Mr. Anderson obtained help from certain friends, without which it is difficult to see how he could have lived to carry on the struggle. The same may be said of the help which he has had from time to time from many sources, for seldom from month to month, from week to week, and sometimes from day to day, has Mr. Anderson known whence would come either the means of subsistence or the means to carry on the contest against the whole strength and influence of the official and judicial powers of the State, which seemed to be perverted to oppress him, wear him out, and crush his resistance. In Trinidad during the long delays in hearing his appeals, deliberately devised for the end just specified, Mr. Anderson for te-

months out of eighteen was the guest of Mr. Tucker, who till he went there to oppose the decision of Sir John Gorrie had scarcely known him by sight. It will here be as well to point out that Mr. Anderson took extreme precautions to secure evidence and support in regard to the general oppression of himself and his fellow colonists. He obtained statutory declarations from clergymen and magistrates which he read with telling effect both in Barbadoes and at St. James's Hall. He had the concurrence of many fellow petitioners in the petitions sent to the Queen in Council. As to his professional conduct he had the written testimony of the only three other medical men in the island of Tobago. He also obtained unanimous votes in support of his professional conduct and rights from the Barbadoes Branch of the British Medical Association, and subsequently, on its formation, from the Trinidad and Tobago branch, so both as to his statements of the injuries done to himself and his fellow colonists and as to his own conduct he occupies a practically impregnable position, and of this these facts, coupled with the report of Sir W. Markby and Sir F. Pollock, should convince the most sceptical.

(To be continued.)

THE NILE EXPEDITION.

THE latest intelligence from this expedition shows that there is great activity at Wady Halfa and that preparation is general for the advance of the force. There are two points on which the authorities may, we think, be fairly congratulated. The first is that the feeling with which the expedition is regarded by some of the tribes in the Soudan appears to have undergone a great change in our favour. Some of those who fought against us at El Teb and Tamai have now become friendly and have not only proffered help to the expedition, but have been making a series of attacks upon Osman Digna's forces, and others have been doing useful work as scouts outside the limit of our own military operations. The other encouraging factor is that the report of the Anglo-Egyptian movement on the Nile has had the effect of drawing off a portion of Osman Digna's troops from Kassala in other directions, thereby enabling the Italian garrison of Kassala to make a successful sortie and defeat the force besieging that place. Official telegrams from Massowah state that the Dervishes threatening Kassala have been routed and driven across the River Atbara, and that the stores of the garrison have been recently replenished. The latest news, moreover, is to the effect that Italian troops will continue to hold Kassala and that the Government do not intend to evacuate the position.

The work of the Transport Department of the Nile Expedition is being energetically pushed forward, and Wady Halfa has been for some time, and still remains, as we have said, a scene of great activity. The railway has now been completed some miles beyond Sarras, and will soon be extended to Akasheh. Rations for the whole force for the next four or five months are being landed and stored at Wady Halfa, and, in short, all arrangements are being made for a serious campaign in the autumn, up to which time the troops will most probably not advance beyond Akasheh, between which place and Wady Halfa railway and telegraphic communication will have, in the meantime, been established.

In addition to the gathering of the Dervishes in and about Dongola a considerable portion of Osman Digna's force seems to have gone in the direction of Suakim, the garrison of which place will no doubt require to be strengthened, but it is hoped and believed that the Egyptian force at Suakim and Tokar—with the aid of the neighbouring tribes friendly to us and strongly opposed to Osman Digna's rule—will be quite sufficient for the present to cope successfully with any troops which Osman Digna can bring against them.

The medical arrangements on the Nile will be a hospital for the Egyptian troops of 340 beds at Wady Halfa, which will act as the provisional base of the expedition, in addition to a portion of the barracks converted into a hospital, a section of a field hospital at Sarras, a hospital at Ambagol, and a field hospital of 100 beds at Akasheh. Hunter Bey, the senior medical officer of the Egyptian army, is making the arrangements, aided by Surgeon-Captain Trask and Surgeon-Captain Penton. It is hoped that river transport by native boats, which is far the most comfortable and best for sick and wounded, will be arranged for the conveyance of sick and disabled men from the stations in front to the base hospital at Wady Halfa. Until this is done their removal must be effected by *cacolets* on camels—an inferior, and indeed unsuitable, method for any sick or badly wounded men. Additional hospital provision and arrangements will have to be made for the British portion of the force. The heat is great—it reaches 107° F.—but it is commonly tempered by a cool breeze from the north at some period of the day. There are considerable diurnal variations of temperature—a difference of as much as 30° F. sometimes taking place between the temperatures of the day and night. The climatic heat is, however, very different to that of India. It is a matter of great importance, of course, that there should be no overcrowding of the troops, that any available means of free ventilation should be turned to account, that the soldiers—especially the European soldiers—should have good cover from the direct effects of the sun, that the camps and camping grounds should be kept scrupulously clean, and that there should be ample supplies of ice. The men of the British battalion are stated to be in fairly good health and in excellent fettle, but there has, as might have been anticipated, already been some inefficiency from sickness among them. As the result of all our previous knowledge and experience we may fairly expect that the principal diseases that will have to be encountered will be fevers—especially heat fevers and typhoid fever—diarrhœa and dysentery, with cases of sunstroke and heat-exhaustion. It is understood that British troops will not be sent to Egypt to take part in the campaign until the hot weather is over, and that Sir Redvers Buller will assume command of the expeditionary force when the advance on Dongola is made. As we have already said, the army generally has the greatest confidence in the proved capacity and soldier-like qualities of Sir Redvers Buller, who has already made a reputation for himself in the fields of South and North Africa. It seems to be generally agreed that great improvement has taken place in the military bearing, discipline, and general appearance of the Egyptian troops.

Public Health and Poor Law.

LOCAL GOVERNMENT DEPARTMENT.

SANITARY ADMINISTRATION IN THE PORT OF LONDON.

THE current half-yearly report of Dr. Wm. Collingridge, the medical officer of health of the Port of London, is very interesting reading, and it contains, moreover, suggestions of much value. The Cholera Surveys of recent years which have been undertaken by the Medical Department of the Local Government Board have done excellent work in serving to stimulate port sanitary authorities throughout the country to a better comprehension and execution of duties imposed upon them by the Legislature: and the energetic and praiseworthy action of the Corporation of London has provided a fitting example which other port sanitary authorities may well follow. It is surely in keeping with the spirit of the times that the port of the greatest city in the world should administer its affairs with no niggardly hand—it can, indeed, well afford to set an example both in administration as well as in liberality. During the half year referred to by Dr. Collingridge's report 14,054 sanitary inspections of vessels were made, and it was discovered that in 3·8 per cent. of these cleansing orders were necessary. In connexion with these inspections it is stated that the proportion of dirty forecastles has steadily decreased since systematic inspections have been carried out. Of the total number of vessels inspected, 82·4 per cent. were British, 9·05 were Swedish and Norwegian, 3·29 were German, and the remaining nations were represented in smaller percentages. Many of the improvements carried out during the year were in regard to lighting and heating, and Dr. Collingridge very properly insists strongly on the importance from a sanitary standpoint of affording as much light as possible. In connexion with the question of structural requirements Dr. Collingridge refers to the necessity of the port sanitary authorities inspecting the plans of all

vessels prior to their construction, as, although the officers of these authorities would have little to say to the design of a vessel, they would be able to suggest improvements as regards fittings, ventilation, lighting, &c., and thus spare infinite subsequent trouble to all concerned. The important modifications which have been recently introduced into the instructions of the Board of Trade as to the survey of crews' spaces, &c., are referred to with much satisfaction by Dr. Collingridge, and he especially mentions the prevention of condensation in the berths and the provision of proper lighting and ventilation. In the instructions referred to it is for the first time laid down that the minimum size of bunks in vessels built or measured after the issue of the instructions shall not be less than six feet long and two feet wide. Medical inspection on the part of London has, Dr. Collingridge observes, worked without a hitch and with but the least delay to shipping; he contemplates that the Quarantine Act when in force will by the removal of needless restrictions still further facilitate matters. The enormous amount of inspectorial work which is necessitated in the Port of London may be gathered from the fact that the limits of the district extend from Teddington to the Nore. It has been found, in fact, that with the two steam launches hitherto at the disposal of the sanitary authority it is impossible to carry out the inspection thoroughly over the whole area, and Dr. Collingridge has asked the authority to provide a third launch. He points out that under the Public Health (London) Act, 1891, it is as much the duty of the port sanitary authority to cause inspection to be made of the ships in their district as it is for an inland sanitary authority to inspect the houses in theirs, and he shows that with the present fleet such inspection is impossible. The port sanitary committee has had Dr. Collingridge's request under their consideration, and we are glad to see that before deciding upon the matter they adopted the very sensible course of themselves making trips down the river and thereby ascertaining the impossibility of complete inspectorial supervision with but two steam launches. A considerable portion of Dr. Collingridge's report is devoted to the important subject of food inspection, a matter which engages a large portion of the inspectors' time. For instance, during the six months under review there were destroyed 451 carcases of mutton and lamb and 1546 quarters of beef, besides numerous cases of eggs, fruit, and fish. A very large number of frozen rabbits and hares are imported during certain months of the year from New Zealand and Australia, and these are all inspected on their being unloaded from the vessels. Much care has to be exercised in dealing with these rabbits in transit from the docks, as they are extremely susceptible to changes of temperature and decomposition readily ensues. The importance of this supervision of our food-supplies entering by sea which is exercised by the officers of the London Port Sanitary Authority cannot be overrated, and Dr. Collingridge draws attention to the possibility of the introduction of infection by meat and milk, insisting that inasmuch as there is no information as to the condition during life of the animals which furnish the meat and milk it is necessary to be the more particular in subsequent examination. In the appendix to the report the sanitary committee have published the whole of Dr. Theodore Thomson's very thorough report to the Local Government Board upon his survey of the London Port Sanitary District. In conclusion, we commend Dr. Collingridge's report to port medical officers of health, and we trust it will find its way into their hands.

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

In thirty-three of the largest English towns 6451 births and 4164 deaths were registered during the week ending April 11th. The annual rate of mortality in these towns, which had declined in the five preceding weeks from 20·7 to 18·3 per 1000, rose again last week to 20·0. In London the rate was 20·3 per 1000, while it averaged 19·8 in the thirty-two provincial towns. The lowest rates in these towns were 13·0 in Brighton, 13·3 in Croydon and in Derby, 14·2 in West Ham, and 14·5 in Huddersfield; the highest rates were 22·0 in Salford, 24·7 in Oldham and in Bolton, 25·1 in Manchester, and 27·5 in Leeds. The 4164 deaths included 666 which were referred to the principal zymotic diseases, against 631 and 615 in the two preceding weeks; of these, 276 resulted from measles, 206 from whooping-cough, 76 from diphtheria, 42 from diarrhœa, 40 from scarlet fever, 24 from "fever" (principally enteric), and 2 from small-pox. No fatal case of any of these diseases occurred last week in Huddersfield; in the other towns they caused the lowest death-rates in Brighton, Cardiff, Bradford, Preston, and Hull, and the highest rates in Wolverhampton, Birkenhead, Bolton, Oldham, and Sunderland. The greatest mortality from measles occurred in London, Bristol, Oldham, Birkenhead, and Sunderland; from scarlet fever in Salford and in Bolton; from whooping-cough in Bolton, London, Salford, Leeds, and Derby; and from "fever" in Wolverhampton. The 76 deaths from diphtheria included 45 in London, 4 in Birmingham, 3 in West Ham, and 3 in Bolton. Two fatal cases of small-pox was registered in Bristol, but not one in London or in any other of the thirty-three large towns. There were 21 cases of small-pox under treatment in the Metropolitan Asylum Hospitals and in the Highgate Small-pox Hospital on Saturday last, the 11th inst., against 43, 33, and 23 at the end of the three preceding weeks; 5 new cases were admitted during the week, against 9, 2, and 2 in the three preceding weeks. The number of scarlet fever patients in the Metropolitan Asylum Hospitals and in the London Fever Hospital at the end of the week was 2587, against 2773, 2744, and 2676 on the three preceding Saturdays; 226 new cases were admitted during the week, against 277, 224, and 186 in the three preceding weeks. The deaths referred to diseases of the respiratory organs in London, which had declined in the six preceding weeks from 404 to 270, rose again to 301 last week, but were 102 below the corrected average. The causes of 73, or 1·8 per cent., of the deaths in the thirty-three towns were not certified either by a registered medical practitioner or by a coroner. All the causes of death were duly certified in Bristol, Salford, Oldham, Leeds, and in nine other smaller towns; the largest proportions of uncertified deaths were registered in Birmingham, Liverpool, Blackburn, and Sheffield.

HEALTH OF SCOTCH TOWNS.

The annual rate of mortality in the eight Scotch towns, which had declined in the three preceding weeks from 19·6 to 18·7 per 1000, rose again to 19·7 during the week ending April 11th, but was slightly below the mean rate during the same period in the thirty-three large English towns. The rates in the eight Scotch towns ranged from 12·1 in Paisley and 13·0 in Aberdeen, to 21·8 in Leith and 27·4 in Perth. The 576 deaths in these towns included 29 which were referred to whooping-cough, 20 to measles, 17 to diarrhœa, 12 to "fever," 7 to diphtheria, 6 to scarlet fever, and not one to small-pox. In all, 91 deaths resulted from these principal zymotic diseases, against 52 and 61 in the two preceding weeks. These 91 deaths were equal to an annual rate of 3·1 per 1000, which almost corresponded with the mean rate last week from the same diseases in the thirty-three large English towns. The fatal cases of whooping-cough, which had been 21 in each of the two preceding weeks, rose to 29 last week, of which 18 occurred in Glasgow, 4 in Edinburgh, 3 in Aberdeen, and 3 in Paisley. The deaths from measles, which had been 6 and 8 in the two preceding weeks, further increased to 20 last week, and included 9 in Glasgow and 5 in Dundee. The deaths referred to different forms of "fever," which had been 4 and 6 in the two preceding weeks, further rose to 12 last week, of which 7 occurred in Glasgow and 2 in Edinburgh. The 7 fatal cases of diphtheria also showed a further increase upon recent weekly numbers, and included 3 in Glasgow. The deaths from scarlet fever, which had been 6 and 5 in the two preceding weeks, were 6 last week, of which 3 occurred in Edinburgh and 2 in Glasgow. The deaths referred to diseases of the respiratory organs in these towns, which had been 107 and 87 in the two preceding weeks, rose again to 110 last week, but were 51 below the number in the corresponding week of last year. The causes of 40, or nearly 7 per cent., of the deaths in these eight towns last week were not certified.

HEALTH OF DUBLIN.

The death-rate in Dublin, which had been 24·8 and 25·5 per 1000 in the two preceding weeks, declined to 25·4

during the week ending April 11th. During the thirteen weeks of last quarter the rate of mortality in the city averaged 25·3 per 1000, the rate during the same period being 19·5 in London and 17·7 in Edinburgh. The 170 deaths registered in Dublin during the week under notice were within one of the number in the preceding week, and included 10 which were referred to the principal zymotic diseases, against 7 and 8 in the two preceding weeks; of these, 4 resulted from diarrhœa, 2 from scarlet fever, and 1 each from small-pox, diphtheria, whooping-cough, and "fever." These 10 deaths were equal to an annual rate of 1·5 per 1000, the zymotic death-rate during the same period being 4·1 in London and 2·8 in Edinburgh. The fatal cases of diarrhœa, which had been 3 and 2 in the two preceding weeks, were 4 last week. The 2 deaths referred to scarlet fever, corresponded with the number in each of the 2 preceding weeks. The 170 deaths in Dublin last week included 20 of infants under one year of age, and 44 of persons aged upwards of sixty years; the deaths both of infants and of elderly persons showed a decline from the numbers recorded in the preceding week. Two inquest cases and 4 deaths from violence were registered; and 76, or more than a third, of the deaths occurred in public institutions. The causes of 12, or more than 7 per cent., of the deaths in the city last week were not certified.

THE SERVICES.

MOVEMENTS OF THE MEDICAL STAFF.

SURGEON-MAJOR KEAYS has been posted to Limerick and Surgeon-Major Harran to Cork. Surgeon-Major Dugdale and Surgeon-Captain Daly have embarked for Egypt. Surgeon-Major Adams has been appointed to the Thames District. Surgeon-Captain Gray has been posted to the South-Eastern District and Surgeon-Captain Brown to Cork. Surgeon-Lieutenant Probyn has joined at Chatham, Surgeon-Lieutenant Statham at Edinburgh, Surgeon-Lieutenant Cooper at Canterbury, Surgeon-Lieutenant Brereton at Portsmouth, Surgeon-Lieutenant Forrest at the Curragh, and Surgeon-Lieutenant Grattan at Athlone. Surgeon-Lieutenant Hooper is appointed to the Coldstream Guards in succession to Surgeon-Lieutenant French, transferred to the North-Western District.

ARMY MEDICAL STAFF.

Surgeon-Major-General John Colahan, M.D., is placed on retired pay. Surgeon-Lieutenant-Colonel James Coats, M.B., retires on retired pay. Surgeon-Captain William Henry Bean, half-pay, retires from the service receiving a gratuity.

INDIA AND THE INDIAN MEDICAL SERVICES.

Surgeon-Major R. R. H. Whitefield has been appointed Civil Surgeon of Patna; Surgeon-Major A. Tomes to act as Civil Surgeon of Howrah; Surgeon-Captain F. C. Clarkson to act as Civil Surgeon of Midnapur; Surgeon-Captain H. W. Pilgrim to act as Civil Surgeon of the 24th Parganas, and also to act as Medical Inspector of Emigrants (Colonial Emigration). Surgeon-Captain D. M. Moir is appointed to act as First Resident Surgeon, Presidency General Hospital; Surgeon-Captain E. O'Kinealy to act as Second Resident Surgeon, Presidency General Hospital; and Surgeon-Captain R. Bird to be Resident Medical Officer of the Medical College Hospital, Calcutta. Surgeon-Captain W. C. Vickers, M.B., C.M., to be District Medical and Sanitary Officer, Kistna, vice Surgeon-Lieutenant-Colonel A. J. Sturmer, appointed Surgeon, Fourth District; and Surgeon-Captain P. C. Gabbett to act as Resident Physician, General Hospital. The following promotion is made, subject to Her Majesty's approval:—Surgeon-Lieutenant-Colonel to be Brigade-Surgeon-Lieutenant-Colonel; Andrew Deane, M.D., vice Brigade-Surgeon-Lieutenant-Colonel Henry Black Purves, retired; Brigade-Surgeon-Lieutenant-Colonel William Price, M.D., Indian Medical Service (Madras), Principal, Medical College, Madras, and Senior Medical Officer, General Hospital, Madras, retires from the service subject to Her Majesty's approval.

NAVAL MEDICAL SERVICE.

Fleet-Surgeon Robert Turner has been placed on the Retired List, with permission to assume the rank of Deputy Inspector-General of Hospitals and Fleets.

The following appointments are notified:—Staff-Surgeons: Joseph Crowley, M.D., to the *Grafton;* John L. Aherne to the *Lion;* and John B. B. Triggs, M.B., to the *Active.* Surgeon Harold P. Jones to the *Grafton.*

ARMY MEDICAL RESERVE OF OFFICERS.

Surgeon-Captain William H. B. Crockwell to be Surgeon-Major.

YEOMANRY CAVALRY.

Northumberland (Hussars): Surgeon-Lieutenant A. Brumell to be Surgeon-Captain.

VOLUNTEER CORPS.

Artillery: 3rd Middlesex: Henry Walter Syers, M.D., to be Surgeon-Lieutenant. 1st Hampshire (Southern Division, Royal Artillery): Ernest Frederick Eliot, gent., formerly Surgeon-Captain, to be Surgeon-Lieutenant. 2nd Lancashire: Surgeon-Lieutenant-Colonel J. Johnstone resigns his commission; also is permitted to retain his rank and to continue to wear the uniform of the corps on his retirement. 5th Lancashire: Surgeon-Lieutenant Douglas John Mayhew Bone is appointed Lieutenant. The Highland: Second Lieutenant George Geddes, M.B., is appointed Surgeon-Lieutenant. *Rifle:* 3rd Volunteer Battalion the Royal Fusiliers (City of London Regiment): Surgeon-Lieutenant W. Barter, M.D., to be Surgeon-Captain. 5th Volunteer Battalion the King's (Liverpool Regiment): Surgeon-Lieutenant Michael Joseph Mahony is appointed Second Lieutenant. 2nd Volunteer Battalion the Lincolnshire Regiment: Surgeon-Lieutenant R. E. E. South to be Surgeon-Captain. 1st Volunteer Battalion the East Yorkshire Regiment: Francis William Fullerton, M.D., to be Surgeon-Lieutenant. 3rd Volunteer Battalion the Lancashire Fusiliers: Surgeon-Lieutenant J. T. Smith to be Surgeon-Captain. 1st Volunteer Battalion the Duke of Cornwall's Light Infantry: Surgeon-Lieutenant C. R. Lawrie to be Surgeon-Captain. 1st Nottinghamshire (Robin Hood): Surgeon-Lieutenant W. J. Sprott, M.D., to be Surgeon-Captain.

Royal Engineers: S. R. Dyer, M.D., late Captain, to be Surgeon-Lieutenant to the 1st London Volunteers, and not as stated in our previous issue.

THE ARMY MEDICAL STAFF IN INDIA.

It is well known that some of the authorities in India and the medical service of that country have for a long time been desirous of having the medical charge of the British force serving in India handed over to them in addition to that of the native army. If this were done there would no longer be two military medical services for India, the Army Medical Staff not going to that country in medical charge of the European regiments. The *Army and Navy Gazette* has called attention to the subject and states that a rumour to this effect must be acknowledged to have some foundation, adding that it is believed a scheme has actually been proposed by the authorities at home to those in India for the removal altogether of officers of the Army Medical Staff from India replacing them by officers of the Indian medical service. The scheme is not at all likely, however, to find favour with the present Commander-in-Chief in India or with the military authorities of the European army in that country. However popular and acceptable it would be to the Indian medical service it would be exactly the reverse with that of the British service. The object of the Home and Indian Governments is probably one of supposed economy in the first place, and in the second to have a restricted service for home and the colonies so as to vastly reduce the size of the army medical department and do away with, or materially lessen, the large amount of foreign service of which its officers complain so much at present. The British Government, no doubt, hopes to meet the difficulty of obtaining candidates for the Army Medical Staff by such a wholesale reduction, but a scheme of this kind would revolutionise the service and arouse, we imagine, an immense amount of opposition.

THE BEST BOOT FOR THE INFANTRY.

All interested in the health and comfort of our army will read with interest and pleasure the letter which we print below. Nothing tells so much against a soldier as to be badly shod, nothing makes his toil more arduous and his work less efficient. It does not necessarily follow that the article which wins a prize allotted from an academic point of view is found to be thoroughly efficacious in practical tests, but the boot worn by our troops in Ashanti seems

to have justified the prize awarded to it, and we hope the Adjutant-General will take note of the fact.

To the Editors of THE LANCET.

SIRS,—It really does appear that the Boot question for the Infantry soldier is nearly settled. The boot that won the prize for an Army Boot last year has been tested in Ashanti. Officers and men speak highly of its durability and suppleness. Will the Adjutant-General oppose the pattern? I am of opinion that all public servants in uniform should have a boot of the same quality, pattern, and price.

I am, Sirs, your obedient servant,
W. H. ALLSOPP, Lieutenant-Colonel.

Junior Carlton Club, April 13th, 1896.

MONTHLY AVERAGE TEMPERATURE OF THE AIR AT WADY HALFA.

	1894.			1895.		
	Max.	Min.	Medium.	Max.	Min.	Medium.
January	73·9	46·6	59·5	75·4	45·5	60·1
February... ...	77·2	52·3	63·5	84·7	49·8	66·5
March	88·0	56·1	71·1	91·4	56·6	73·4
April...	94·8	62·4	78·8	97·2	63·0	80·6
May	106·0	71·2	88·7	106·5	73·6	89·9
June...	107·6	75·9	91·4	107·0	73·6	90·3
July	104·7	75·0	89·8	106·2	75·2	90·9
August	103·1	75·0	89·1	104·2	76·1	89·8
September ...	99·9	73·9	86·3	100·2	74·8	87·0
October	100·6	68·3	83·7	93·9	67·3	80·1
November ...	82·4	56·3	69·3	85·3	59·9	72·2
December ...	77·0	48·7	62·4	78·4	51·4	64·2

The mean temperature is calculated from the maximum and minimum of the twenty-four hours, together with observations taken at 9 A.M. and 9 P.M. These tables have been calculated from the weekly returns published by the Egyptian Sanitary Department, to which we may refer readers who may be anxious for more information regarding the climate of Upper Egypt. As the troops advance southwards the heat may be expected to increase, but that other factors besides proximity to the equator influence the temperature is evident from the subjoined table, which has been compiled from the same sources as the other. Wady Halfa, it may be mentioned, is as nearly as possible two and a half degrees south of Assouan.

MEAN TEMPERATURE OF THE AIR AT FIRST AND SECOND CATARACTS.

1894.	January.	February.	March.	April.	May.	June.	July.	August.	September.	October.	November.	December.
Assouan	61·3	63 3	70·9	79·5	90·3	93·6	93·0	90·7	86 9	87·1	72 5	63·1
Wady Halfa ...	59·5	63 5	71·1	78·8	88·7	91·4	89 8	89 1	86·3	83·7	69·3	62·4

Unfortunately, the comparison between the two stations cannot be given for 1895 as the reports from Assouan are incomplete.

THE MATABELE RISING.

The situation in Matabeleland is assuming a grave aspect. Sir Hercules Robinson has arranged to send an Imperial force of cavalry and some mounted infantry into that district as an addition to the volunteers and police force already there. It is thought locally that Sir Hercules Robinson was nevertheless right in advising that reinforcements from this country were not necessary, at any rate at present, as a large number of men accustomed to field service could be easily raised in the country. The fighting has been pretty severe and a number of men of the Colonial forces have been killed and wounded. The Hon. M. Gifford and the wounded generally are reported as doing well. There is a widespread rising of the Matabeles; the white settlers are exposed, of course, to a good deal of danger; and it seems highly probable that reinforcements will have to be sent from this country.

REORGANISATION OF THE INDIAN MEDICAL SERVICE.

A very important notification regarding the new reorganisation of the Indian Medical Service proposed by the Governor-General in Council has been published with the sanction of the Secretary of State for India, and the new scheme is to take effect from the 1st inst. The Medical Services of Bengal, Madras, and Bombay are now amalgamated in one service under the direct administrative control of the Government of India, with a Director-General as head of the amalgamated Indian Medical Service, together with other changes in the direction we indicated last week.

ASHANTI HONOURS.

The Queen has been pleased to give directions for the following appointments to the Most Distinguished Order of St. Michael and St. George, in recognition of services rendered in the recent expedition to Ashanti. To be Ordinary Members of the Third Class, or Companions of the said Most Distinguished Order: — Surgeon-Lieutenant-Colonel Montgomerie Blennerhassett and Surgeon-Major Edmond Munkhouse Wilson.

THE REGULATIONS FOR ADMISSION INTO THE ARMY MEDICAL STAFF.

We recently adverted to, and briefly commented upon, the proposed changes in the system of examination for admission into the Army Medical Service. These changes have since been embodied and published in an Army Order. They are in the direction we have already indicated and mainly with the view of strengthening the examination in medicine and surgery and putting other subjects in a relatively subordinate position.

THE PLAGUE AT HONG-KONG.

According to the latest telegraphic intelligence from Hong-Kong to the Colonial Office sixty-seven cases of bubonic plague occurred in the week ending 14th instant, making 482 cases altogether since the beginning of the year. The disease seems to be confined to the natives, no cases having so far been reported among the European residents.

NAVAL MEDICAL SUPPLEMENTAL FUND.

At the quarterly meeting of the Directors of the Naval Medical Supplemental Fund, held on the 14th inst., Inspector-General T. Russel Pickthorn in the chair, the sum of £55 was distributed among the several applicants.

Correspondence.

"Audi alteram partem."

THE WRITTEN AND UNWRITTEN LAW OF THE ROYAL COLLEGE OF PHYSICIANS, LONDON.

To the Editors of THE LANCET.

SIRS,—The question of advertising by medical men has been much before the public both in the medical and general periodicals of late. There is a resolution of July 27th, 1882, of the Royal College of Physicians of London relating to this matter which reads as follows: "That the system of extensively advertising medical works and the custom of giving, whether for publication or not, laudatory certificates of medicinal and other preparations or of medical or surgical appliances is misleading to the public, derogatory to the dignity of the profession, and contrary to the traditions and resolutions of the Royal College of Physicians." Would you kindly inform me where these "Traditions and Resolutions" are to be found that I may be able to read the subject?

I am, Sirs, yours faithfully,
S. LEONARD CLIFT, M.R.C.S. Eng., L.R.C.P. Lond.

Church-road, Bournemouth, April 16th, 1896.

*** The word "Traditions" almost conveys the answer to our correspondent's question. The greater part of the law of the Royal College of Physicians of London is *unwritten*, consisting only of well recognised traditional principles and their application to particular circumstances. No attempt has ever been made to reduce these principles to a code, and we think that such an attempt would be of doubtful wisdom, as it would considerably fetter the operations of the College and lower its dignity simultaneously. But the College is not without a form of written law. Its authority in matters of professional conduct is wielded by the Censors' Board, and

the proceedings of this Board as embodied in the minutes and read at each quarterly meeting of the College constitute a very important collection of decisions. Certain By-laws, again, have been enacted from time to time by the College to define a line of conduct in particular contingencies, of which those at present in force may be found in Chap. XXVI. of the *By-laws and Regulations of the College*, a copy of which may be had on application to Mr. Fleming, the bedell, at the office of the College. Lastly, certain Resolutions of the College, passed generally on the recommendation of the Censors' Board and aimed at some growing offence against professional honour and good manners, have been printed and a general currency given them. It is such a Resolution that our correspondent has quoted, and it was passed by the College on July 27th, 1882.—ED. L.

MATERNAL SYPHILIS.

To the Editors of THE LANCET.

SIRS,—Many of the difficult questions connected with syphilis and maternity are dealt with in Dr. Coutts's able and interesting Hunterian Lecture in THE LANCET of April 11th. Quite unaware of Dr. Coutts's lecture and views I submitted to you a paper on the same subject on March 25th, approached rather from the gynæcological side, in which I ventured to remark on the prevalence and manifestations of syphilis in married women subsequently to abortion or delivery, and I attempted to urge the primary origin of syphilis in the mother rather than the "paternal syphilis" of the fœtus with "syphilis by conception" in the mother. Dr. Coutts states that "all observers are agreed in the fact that a very large proportion of the mothers of syphilitic infants exhibit no outward evidence of the complaint even after prolonged and careful search." Dr. Coutts mentions 100 mothers who showed manifestations and 100 who were *apparently* free from syphilis. This percentage agrees with the figures of Mr. J. Hutchinson, who also has stated: "It is exceptional for such mothers to suffer from ostensible syphilis." Such statements as these have considerably perplexed me, for while I have been willing to admit apparent immunity in the mothers of syphilitic children brought to children's hospitals, I have been very much struck with the constant and spontaneous complaint of mothers who in gynæcological practice attribute their ill-health to abortion or confinement with no history of previous illness. Such complaints may be classed as debility, general ill-health, severe headaches, loss of or thinning of hair, sore throats, eruptions, palmar psoriasis, subinvolution and prolapse, leucorrhœa and hyperæmia of the vaginal mucous membrane, menorrhagia, erosions of the os, endometritis, chronic ovarian and tubal disease, and superficial sores of the anus and affections of the rectum. If these are not ostensible signs of syphilitic infection they in many cases are a sequel to a syphilitic pregnancy, while gummata, as in Charrier's case, and diseases of the bones and nervous system are by no means uncommon in married women in whom no suspicion of syphilis has arisen, but who have been pregnant by a husband who has had syphilis in early life. I regret I am unable at present to give complete and comparative statistics; I am, however, indebted to Mr. Henry Lee for kind permission to make use of his case-books, and I have collected a sufficient number of cases myself to satisfy me that ill-health in women subsequently to a syphilitic conception is far more common than is supposed, and that the views of Charrier, Cullerier, Notta, and others, who hold that "every syphilitic child is born of a syphilitic mother," are worthy of greater clinical recognition. A. Fournier states, "Syphilis in the child nearly always implies syphilis in the mother"; while Mr. Hutchinson himself, in interpreting Colles' views, sets forth that immunity and syphilisation are synonymous, and that the possibility of later manifestations cannot be excluded. Moreover, the works of Diday, Tyler Smith, and L. Parker clearly demonstrate the importance and recognition of syphilis in the mother subsequently to a syphilitic conception. If a mother is thus capable of being infected, it is obvious that the power of transmission to the offspring outlasting that of direct infection of the mother is of small significance.

The theoretical explanation of syphilis in the fœtus and in the mother is possibly of second importance to the clinical recognition of syphilis in parous women. At the same time it is of such interest that it compels attention. I confess "paternal syphilis" and "syphilis by conception" do not satisfy me. The absence of primary disease in the mother applies to both paternal and maternal origin, for in nulliparous women primary disease may be so slight as to escape notice or altogether absent, while the lumbar glands may be enlarged and the inguinal glands normal. The absence of syphilis in the mother with manifest syphilis in the fœtus is not conclusive, for absence of manifestations in a mother who has contracted it in the usual way is, as Dr. Coutts notes, not impossible. While Dr. Coutts considers there is no proof of the attenuation of the syphilitic virus in the male I confess I lean to the primary syphilisation of the wife, with partial or complete immunity, till pregnancy disturbs such latency and manifestations result subsequently to abortion or delivery. The following points seem to support such theory: 1. It is no uncommon thing to find that intercourse and marriage lights up latent disease in men, and genital superficial lesions or modified urethritis appear. In a disease dependent on periodical activity of germs and production of antitoxin it seems almost unreasonable to doubt that the genital secretions of the male or the relapsing lesions of the penis are incapable of producing at a period of minimum activity syphilisation without obvious manifestations. 2. In a few cases that have presented themselves to me I have noted that pregnancy occurring in women who had previously suffered from syphilis, the syphilis which was latent was lighted up and manifested itself in ulcerated throat, genital sores, and eruption. 3. In pelvic absorption the extent of glandular distribution may considerably modify the virus and general infection.

The maternal origin of syphilis in the fœtus in every case appears to be more reasonable than that the spermatozoon possesses the ability to infect the fœtus and secondarily the mother. As regards this point I understand Dr. Coutts disbelieves, as I do, in "syphilis by conception," but I do not follow him when he admits immunity by conception, partial or complete, which I take it, is syphilis by conception. One other point I would like to touch on in Dr. Coutts' valuable lecture. He explains Diday's "law of decreases" by immunity gained by the evolution of some chemical principle or antitoxin antagonistic to the growth of the germs. That is one explanation of immunity in general, but I hold strongly to the theory of elimination of syphilis through the skin and secretions, and beg to quote Dr. J. F. Payne in his manual of General Pathology: "It is one of the oldest traditions in medicine that diseases which produce an exanthematous eruption are thrown off by the skin, which, expressed in modern language, means that the poison, or micro-organism, is eliminated by exfoliated epidermis and by the cutaneous secretions. Considering the case of syphilis, there is nothing impossible or even improbable in this theory."

I am, Sirs, yours faithfully,

JOHN A. SHAW-MACKENZIE, M.D. Lond., &c.,
Formerly Registrar to the Victoria Children's Hospital, and late Pathologist and Physician to the Out-Patients,
April 13th, 1896. Chelsea Hospital for Women.

THE ETYMOLOGY OF MEASLES.

To the Editors of THE LANCET.

SIRS,—Dr. William Sykes, in a learned paper on the Origin of English Disease Names,[1] which will have been read with general interest, has, in following Professor Skeat as to the derivation of "measles," taken up a position which I had already shown[2] to be untenable. Trench, in his "Select Glossary," had derived measles from the mediæval Latin *miselli*, diminutive of *miser*, meaning the leprous, although he did not explain how measles came to be associated with leprosy. Professor Skeat, in his "Etymological Dictionary," did not doubt—it is, indeed, beyond doubt—that *miselli* reappears in the Norman-French form of mesels, or mesles, or mezeals; but he rejected Trench's etymology of measles on the ground that it is not the same word as mesles. "The spelling with the simple vowel *e*," he says, "instead of *ea* or *ae*, makes all the difference. The confusion between the words is probably quite modern." This bland assertion, improbable on the face of it, seeing that it relates to so inconstant a thing as spelling, has sufficed for Dr. Sykes, who thereupon pronounces

[1] THE LANCET, April 11th, 1896.
[2] History of Epidemics in Britain, vol. i., p. 632, 1893.

me to be "probably in error," as well as "dogmatically" so, in defending the old derivation of Trench and in making it intelligible by showing that Gaddesden had actually grouped the small spots of morbilli with the broad, dusky red spots on the legs of *pauperes et consumptivi*, who were called "anglicè *mesles*." I had already shown that the separation in orthography between mesles and measles asserted by Professor Skeat had no existence. Four English writers of the Tudor period—Pace (in a letter of 1518), Skene, Cogan, and Lodge—use the forms mezils, mesillis, or mesels, where they mean morbilli; while four others—Elyot (1541), Phaer, Clowes, and Kellwaye—write the word with *ea*, or in the way that has become fixed by subsequent usage. There was no uniformity: how could anyone look for it? Again, in the printed text of Shakespeare (who spelt his own name in five different ways) we find, "Those meazels which we disdain should tetter us" (*Coriolanus*; Act IV., Sc. 1), meaning a scurvy rabble, such as the mesells or lazars or beggars in the "Vision of Piers the Ploughman," of whom Professor Skeat was doubtless thinking. There was, in fact, only one word, with the usual latitude of spelling, still used occasionally in its original sense as late as the time of Shakespeare, but in its common use diverted to the meaning which Gaddesden's reference to it as a larger form of morbillous spots, in his chapter "De Variolis et Morbillis," had opened the way for. His "Rosa Anglica" had great authority for more than two centuries, and was printed almost as soon as printing began, so that it is not difficult to understand how mezils, or mesles, or meysyls, or measles should have got that specific meaning of morbilli which we find it to have about the beginning of the Tudor period. The first mention of an epidemic under that name which I have noted is under the date of January, 1483, a certain infirmity then reigning, as was said, in Canterbury—namely, le meysyls, by reason of which the King did not accompany the Queen into the city. Dr. Sykes thinks that I had erred, as he supposes, by taking a too exclusively English standpoint in examining "the literature of the subject," meaning that I had paid no heed to the dictionary derivation of measles from the Dutch *maezeln*. But how can one's point of view be too exclusively English when we discover the very fountain and origin of this English medical term in a freak of classification by Gaddesden? Measles having been shown to be the same word as mesles, the association of the latter with morbilli in the "Rosa Anglica" surely determines our priority over the Dutch.

I am, Sirs, yours faithfully,

C. CREIGHTON.

Great Ormond-street, London, W.C., April 13th, 1896.

MIDWIVES' REGISTRATION.

To the Editors of THE LANCET.

SIRS,—We trust you will allow us to remind those members of the profession who are in favour of the education, registration, and supervision of midwives that a Bill for securing these objects has been set down for reading in the House of Commons on May 6th. We desire to point out that no time should be lost in bringing the question under the notice of Members of Parliament and putting the case for legislation fairly before them. We are aware that a number of our brethren are opposed to such legislation, but we know also, and we think it very important that Members of Parliament should know, that a very considerable number are in favour of it. The object of this letter is to urge the advocates of legislation to give their active support to the present Bill, which is identical with the amended Bill of Lord Balfour of Burleigh, introduced and read a second time in the House of Lords last year. We are, Sirs, yours faithfully,

ROBERT BOXALL, M.D. Cantab.,
ROWLAND HUMPHREYS,
Hon. Secs., Midwives' Registration Association.

Fellows-road, N.W., April 13th, 1896.

To the Editors of THE LANCET.

SIRS,—In your issue of April 4th your Liverpool correspondent calls attention to the threatened dismissal of the visiting staff of the Liverpool Lying-in Hospital and to the appointing of midwives in their stead. This is a speedy nemesis, and should open the eyes of all practitioners who are in favour of the so-called registration of midwives. For some years the medical staff of this hospital has lectured and granted elegant diplomas to midwives. It has also stood by and allowed their district midwives to attend, on their sole responsibility, all out-door confinements, and without the aid of the district medical staff. Why, then, it is asked, can the visiting medical staff take valid objection to the plan being put into force in connexion with women confined in their hospital—which is, and has been, in force with their approbation among the home patients? Consistency of conduct is a valuable weapon, and it being forgotten is likely to recoil some day upon those who lay it aside. I do not, however, wish to blame unduly the visiting medical staff; I wish to use it as an illustration of the true and ulterior motives of the supporters of midwives registration. Thus Mr. H. C. Burdett suggested that no resident medical officer should be employed in small lying-in hospitals, but that his place should be taken *by a midwife*.[1] This excludes resident medical officers. The committees of the City of London Lying-in and of the British Lying-in will not allow medical students to be trained in these hospitals in midwifery. This excludes medical students. In March, 1895, the Leicester board of guardians tried to appoint a midwife to take the place of their district medical officer, but the Local Government Board would not allow it. This proposed to do away with the district medical officer's conducting pauper confinements. In November, 1895, the Peterborough guardians ("guardians" of the poor in inverted commas) sent a circular letter to all the other Poor-law guardians in England asking them to resolve: "That the members of the board are of opinion that it is desirable that boards of guardians shall have discretionary power of appointing duly qualified midwives for attendance at childbirth *in place of the district medical officer*, subject to the condition as laid down in the Poor-law Board's Circular, No. 88." A most modest suggestion for those who should be *the real* guardians of sick women and infants! In the Hospital Annual, 1891, Mr. Burdett again writes: "It behoves all midwives just now to be sure of obtaining a good certificate. ..... *Every reason which was brought forward for the registration of medical men applies also to midwives.* ....." Another modest remark! Dr. W. Grigg, lecturer to pupil midwives at Queen Charlotte's Hospital, said: "I am sure you will agree with me in hoping the day is not far distant when all midwifery will again fall into the hands of women." Why, I ask, should the lying-in room of the poor be again made the first stage to the chamber of death? The Midwives Institute, in its prospectus, modestly states: "As some confusion exists in the public mind as to the difference between midwives and monthly nurses, it may be well to state that a midwife is qualified to attend all cases of natural labour—that is, she undertakes the cases herself *without a doctor, and is, in fact, engaged instead of one.*"

I think, Sirs, the above quotations show clearly that the promoters of this iniquitous Bill propose (*a*) to exclude medical students from lying-in hospitals for training; (*b*) to exclude all resident medical officers: (*c*) to exclude all visiting medical staffs; (*d*) to exclude the district Poor-law medical officers from attending Poor-law confinements, and (*e*) generally to degrade and prostitute the Medical Act, 1886, and to revert to those death-dealing times when midwifery was an occupation of the uneducated and dangerous. At least thirteen women die each day in England in childbed. Is not this sad and disgraceful death-rate—not to mention the sick and maimed rates—sufficient to prompt us to insist on the elevation of the practice of midwifery to a much higher level than it occupies to-day, and to do everything to prevent its degradation and retardation?

I am, Sirs, yours faithfully,

Liverpool, April 15th, 1896. ROBERT R. RENTOUL.

"THE EFFECT OF MUSCULAR WORK UPON THE ALKALINITY OF THE BLOOD."

To the Editors of THE LANCET.

SIRS,—In THE LANCET of April 11th (p. 1020) Mr. Fotheringham contrasts a statement of mine in THE LANCET of March 7th (p. 611) with one in the paper by Dr. Hutchison which follows it, and asks, "Which is the correct view?" I reply that probably both are correct, as their opposition is apparent rather than real. The conclusion I draw from my facts and figures (p. 614) is "that the effect of exercise is to increase the function of urea," and as I have pointed out in my book that the excretion of urea and of acid in the urine

[1] See Pamphlet, No. viii., 1888, Hospitals Association.

generally rise and fall together, it follows that the effect of exercise is to raise the acidity of the urine and diminish the alkalinity of the blood. And my Figures 1 and 2 (p. 611) show that while there is at first a fall of urea and acidity, this is followed by a rise that more than makes up for the fall, so that the total effect of the exercise is to raise the acidity of the urine and probably to diminish the alkalinity of the blood; and Dr. Hutchison points out (p. 616) the correspondence between the increase of the blood's alkalinity after meals and the appearance of the "alkaline tide" in the urine, and he adds, "The latter is to be regarded as the expression and result of the former." Mr. Fotheringham's statement that my entire theory of the cause of fatigue rests on the assumption that the effect of exercise is to increase the alkalinity of the blood is only half the truth, as my thesis is that fatigue is the result of the defective capillary circulation which excess of uric acid in the blood produces, and that if the uric acid has not been introduced (vegetarianism) or has been previously cleared out by solvents the alkalinity of the blood is a matter of no consequence. But, as is above shown, and as Mr. Fotheringham will find further reasons for believing in my book, the changes in the acidity of the urine are to a certain extent good and reliable indices of the corresponding changes in the alkalinity of the blood.

I am, Sirs, yours faithfully,

Brook-street, W., April 14th, 1896. ALEXANDER HAIG.

"THE DUTIES OF DIVISIONAL SURGEONS IN CASES OF INFECTIOUS DISEASES."

To the Editors of THE LANCET.

SIRS, Dr. W. Thyne complains that my letter is no answer to his inquiry and that I admitted two flagrant breaches of professional etiquette. I beg to differ with him. I have done nothing of the kind, as I fail to see that I have done anything unprofessional. Dr. Thyne adduces several other instances of similar misconduct occurring in his practice. He says some months ago scarlet fever attacked several families of the police force. "In one instance the divisional surgeon ordered the family out in the garden at the end of a fortnight (at least, so the mother told me). I was also told that the inunction of a medicament which I ordered had not the sanction of his approval. In another case the divisional surgeon got the patient out of bed in order to examine his throat." To the above charges I simply have to say that they are totally untrue. With the exception of the two cases mentioned in his letter of March 21st, I have not seen any case of infectious disease amongst the families of the police for sixteen months in which he has been the medical attendant. Dr. Thyne also says that other divisional surgeons whom he had consulted disclaim any mission to offend professional propriety. I quite agree with them on that point; I had none when I had the whole of my brother practitioners to work with; but now I have a gentleman to contend with who degrades his profession, who undersells his brother practitioners by taking away their private patients and offering to attend a whole family for 2½*d.* per week, against 6*d.* paid by all the other clubs in this town. Notwithstanding Dr. Thyne's threat to report me to Mr. Mackellar, the chief surgeon, I can assure him I have no malice towards him and that when he gives up his ½*d.* fees divisional surgeons and his fellow practitioners will be delighted to show him all the courtesy that is due to him as a gentleman and a professional man.

I am, Sirs, yours faithfully,

W. J. HARNETT, F.R.C.P. Edin., D.P.H.,

Barnet, April 14th, 1896. Divisional Surgeon, Barnet.

*** This correspondence must now cease.—ED. L.

DR. BOUDET DE PARIS' "STETHOSCOPE AMPLIFICATEUR" AND THE PHONENDOSCOPE.

To the Editors of THE LANCET.

SIRS,—I have been somewhat surprised to notice that although the phonendoscope has been for some time before the public and a detailed description of it appeared in the columns of THE LANCET of Feb. 29th, no one has thought fit to point out that it is simply a modification, and I may say a very trifling one, of a stethoscope that has figured for years in a French catalogue. It is true that the precursor of the phonendoscope would seem to be as little known in its native country as in England, for a high clinical authority to whom I showed it recently, pointing out the identity of the two instruments, at first supposed I was attempting to vindicate the claims of an English inventor. The *Comptes Rendus de la Société de Biologie* of March 6th contain, moreover, an account of a demonstration given there by Dr. Bianchi, with cuts of his instrument and figures illustrating the localisation of organs by a *new method* of investigation, and no one appears to have had a word to say as regards priority. If any excuse beyond that of doing justice to one who is no more is necessary for raising this question, I may say that personally I owe a kind of debt of courtesy to the late Dr. Boudet de Pâris which I am thus enabled to discharge, although fifteen or sixteen years ago I called attention to the antecedent claims of another person when he invented his electric diapason.

Dr. Boudet de Pâris invented a number of instruments for studying the sounds of the heart and arteries, all of which may be found in the catalogue of C. Verdin, the well-known maker of philosophical apparatus—the sphygmophone, the cardiophone, the micro-stethoscope, and the "stéthoscope amplificateur à membrane d'ébonite." The first three, as well as a myophone, have electrical transmission of the sound from a microphonic receptor to a telephonic ear-piece, but the "stéthoscope amplificateur" is practically the phonendoscope. The only difference is in the shape and the arrangement of the membrane, which, I venture to think, is better in "Boudet's stethoscope." Dr. Boudet de Pâris' stethoscope consists of a hollow cone with a membrane or plate fixed about half an inch from the open base; there is a stem as in the phonendoscope, which can be brought into play when fine localisation is desired by a screw. When the stem is screwed away from contact with the skin the instrument is the same as the phonendoscope without the second plate, which is removed when the stem is not employed. Boudet's stethoscope appears to me superior in that the vibrating membrane is more perfectly insulated from any sound except that which comes from beneath the portion of skin enclosed by the rim of the chest-piece.

Dr. Bianchi speaks of a new method of mapping out organs by his instrument, and the same *Comptes Rendus* gave diagrams showing the position of the liver, spleen, kidneys, and other organs. The effect of drinking on the contour of the stomach is shown with a precision that reminds one of the diagrams of modifications of heart dulness lately published by Schott's pupils. The following is the *modus operandi*. The button-shaped end of the stem is placed on the organ to explore and the vicinity stroked gently "as if smoothing ruffled fur." The stroking may be centripetal, centrifugal, or parallel to the contour Whilst on the organ a rough sound is heard; when its limit is reached the timbre suddenly changes. One lobe of the lung may be differentiated from another, and one cavity of the heart from the other, the exact line of the intraventricular septum determined, &c. I will not discuss the possibility of these delicate delimitations, but here again, Is Dr. Bianchi right in presenting the method as his own? There is not a word about any such mode of exploration in the prospectus which accompanied the phonendoscope two months ago, where it simply claims to be an intensifier of sound. Dr. Bianchi has, in my opinion, accidentally no doubt, re-invented a "stéthoscope amplificateur" which is not only identical in principle with that of its prototype, but, notwithstanding the difference of form, identical in amplifying power. There is only one difference between the two instruments, and that is not of intensity but of quality. For some acoustic reason the phonendoscope is clangorous and metallic. This would, perhaps, be of no importance in auscultatory percussion, as we are listening to sounds of our own creating and all that is required is distinctness; but in auscultation of sounds emanating from within the thorax we must be sure of having them transmitted without modification of their quality. In this respect "Boudet's stethoscope" is a much more perfect instrument, and it is most surprising to me that its existence should be so little known.

I am, Sirs, yours truly,

April 13th, 1896. OSCAR JENNINGS.

"THE QUESTION OF MEDICAL DEFENCE."

To the Editors of THE LANCET.

SIRS,—I was very glad to see Dr. Lovell Drage's letter in THE LANCET of the 4th inst., although, like yourselves, I do

not agree with his principal conclusion. I am fully in sympathy with the proposed enlargement of the powers of the British Medical Association, but should be sorry to see the absorption of the defence unions by this body. We know that these unions have hitherto done their work excellently well; we do not know that they would be equally efficient if merged in the larger association. It should be remembered that medical defence has a collective as well as an individual bearing. The latter is well looked after by the defence unions, but they do not touch the former, which concerns the defence of the whole profession in any particular locality against enemies from without—e.g., the societies trading in medical attendance—and foes from within—e.g., members of the profession who adopt reprehensible practices which yet may not be "infamous" in a legal sense.

The difficulty in constituting the British Medical Association a court of control is that it has not, and cannot have, any greater punitive power than expulsion from itself, which to many is no penalty at all. The corporations, however, have already very extensive powers, which the profession would gladly see increased if they became representative bodies. It is to them, therefore, that we should turn our attention, and I invite Dr. Drage and those who think with him to support the effort which is now being made to secure representation for the Members of the largest corporation of all, the Royal College of Surgeons of England.

I am, Sirs, yours faithfully,

April 12th, 1893. W. G. DICKINSON.

"SUBCUTANEOUS EMPHYSEMA OCCURRING DURING LABOUR."

To the Editors of THE LANCET.

SIRS,—As Dr. Moffat says in THE LANCET of March 28th the above is a somewhat rare accident. In January of this year a primipara whom I attended showed well-marked emphysema over the thorax, face, and neck. This appeared after the second stage of labour was over and disappeared in about six days. It is of interest to record that she had emphysema in the same regions during an attack of influenza some years ago. The labour was rather tedious and the forceps were used. During the labour the patient had several bad fits of coughing (due to bronchial catarrh), which may have been the direct cause of the subcutaneous emphysema.

I am, Sirs, yours truly,

April 13th, 1896. ALEXANDER INNES, M.B. Aberd.

PUBLIC HEALTH APPOINTMENTS AND THE "LOCAL" CANDIDATE.

To the Editors of THE LANCET.

SIRS,—The recent election of medical officer of health for Sunderland is but another example of the useless and irritating expenditure of time, money, and personal comfort into which busy sanitarians in important public positions are so often unnecessarily led by the specious advertisements of sanitary authorities. To corporations with no soul to save or body to kick the mere fact that a "local" candidate has declared his intention to face the starter is too often quite sufficient to ensure his success (be his merits or demerits what they may) against the most highly qualified "stranger." The applicants for the appointment in question included one of the recent temporary inspectors of the Local Government Board and the health officers of several large Lancashire and Cheshire towns, men of proved ability and administrative experience. The Council nevertheless, by an overwhelming majority, entrusted the health interests of 140,000 people in this notoriously typhoid-stricken town to the hands of an estimable general practitioner, possessing the necessary academic qualification, but virtually without further practical experience of the duties of such a post. Comment is unnecessary; but I may, perhaps, be permitted to suggest to the town councillors of Sunderland and to others similarly actuated that under such circumstances it would in future be more straightforward to include in their invitation for applicants a statement of preference for any legally qualified *local* candidate. Then medical officers of health who are unable to practise the Scriptural precept and gynæcological feat of being born again (the accouchement, of course, to take place in the town they desire) will only have themselves to thank for their failure there.

I am, Sirs, yours faithfully,

April 14th, 1896. SEMPER VIGILANS.

FEVER HOSPITALS.

To the Editors of THE LANCET.

SIRS,—The authorities of the London Fever Hospital are making large additions to their institution in Liverpool-road, presumably for the accommodation of an increased number of patients suffering from infectious diseases. The new wards will be within a few feet of my garden. Will you kindly inform me what public authority (if any) regulates the erection of such buildings, or can any person or number of persons build fever wards where they choose in London? Thanking you in anticipation,—I am, Sirs, yours obediently,

Gibson-square, Islington, N., April 7th, 1896. H. G. D.

*** We rather doubt the conclusion arrived at, having been informed that the governors of the hospital have decided to improve their ward accommodation and to pull down some of the existing buildings, hence we should not be surprised that, compared with the past, the accommodation provided will in the future be less rather than more than it was. As regards the "few feet" referred to, it will be remembered that the limit of ascertained safety adopted by the Local Government Board and all sanitary authorities for the treatment of infectious fevers other than small-pox is actually based on the long experience of the London Fever Hospital, where the buildings intended to receive infected persons and things stand 40 ft. from the boundary of the hospital site. With this 40 ft. it was found that even where the admissions of fever cases numbered 3000 a year no spread to the houses around occurred. We can hardly believe that the governors are departing from this settled precedent of safety. We believe that apart from an injunction no remedy would apply, but we should advise our correspondent to learn the actual facts by communication with the hospital authorities.—ED. L.

LIVERPOOL.

(FROM OUR OWN CORRESPONDENT.)

Death of Mr. George Holt.

IN the death from pneumonia of Mr. George Holt, head of the well-known firm of Lamport and Holt, Liverpool has lost a prominent citizen and University College, Liverpool, a true friend. One of the promoters of that foundation, he ever took the greatest interest in its success, which was substantially shown by his first subscription of £10,000 which was requisite to complete its equipment for incorporation in the Victoria University. It was in its medical school that he took a special interest, and his benefactions to it have been numerous. The chairs of Physiology and Pathology were endowed by him in the amount of £10,000 each, to which was added a further sum of £10,000, for the maintenance of laboratories in those branches of investigation. In addition to these benefactions he presented its medical faculty in 1886 with the sum of £2000 for distribution during the ten succeeding years in tutorial scholarships of the value of £100 each. These have been of the greatest service to industrious students in affording them opportunities for research in special departments of the medical school which otherwise might not have occurred to them. He further fitted up in a complete manner Ashton Hall as a pathological and bacteriological laboratory which is one of the most complete of its kind in this country. Besides providing accommodation for the teaching of morbid anatomy, pathological chemistry, and bacteriology, provision is also made for private investigation in pathology. This building further contains the museums of hygiene and materia medica. This does not exhaust the list of his benefactions; a further sum of £1000 was given as a donation to the college library, to be expended in annual instalments of £100. He was also a generous contributor to the maintenance fund of the college and a warm friend of education in general. Indeed, it is probably as a benefactor of University College that his name will live longest in local memory. He presided at the annual meeting of the Royal Infirmary on Jan. 30th, looking the picture of

health, and on his retiring from the chair unostentatiously presented the funds of that charity with the handsome donation of 500 guineas. A large and representative attendance at the funeral testified to the esteem in which he was held by all classes.

Glanders in Liverpool.

At the weekly meeting of the Health Committee, held on the 9th inst., attention was drawn to the alarming spread of glanders among horses in Liverpool. Both the medical officer of health and the veterinary superintendent, it was stated, were desirous of taking drastic measures, since the disease was serious not only to horses but to men also. In one stable seven horses had to be killed. It was urged that the committee should approach the Board of Agriculture on the subject, as it was necessary to have further powers. A member stated that at present horses were sent out from infected stables to work without restriction throughout the city and to drink at the same troughs as other animals. Alderman Bligh mentioned as within his own experience a fatal case of glanders contracted by a woman from a diseased horse, and felt, with other members, that it was absolutely necessary that the committee should have some powers of quarantine. A special committee was appointed to inquire into and to report on the matter, with power to wait as a deputation on the Board of Agriculture and on the Lancashire County Council. The deputation, consisting of two aldermen and two members of the city council together with the medical officer of health and the veterinary superintendent, proceeded to London on Monday to wait upon the Board of Agriculture and to confer with the officials of the London County Council as to the best means of stamping out the disease.

Liverpool Workhouse Extension.

The limited accommodation in this workhouse for able-bodied paupers has long been a subject of anxiety to the guardians of the parish. Several schemes have been suggested for relieving the pressure on the available space. At the last meeting of the select vestry the recommendations of a special committee appointed to consider the matter came up for discussion. The chairman moved the adoption of the report, which recommended that a site of not less than thirty acres be secured within easy access of the parish, and that on it should be placed a thoroughly equipped asylum for the bedridden and infirm; that the existing buildings at Kirkdale (which are now used as schools), with such slight alterations as circumstances might require, should be utilised as a relief workhouse for healthy inmates, and that the large building on Brownlow Hill, in which there are now upwards of 1000 medical and surgical cases besides infirm and able-bodied paupers, should be used as a hospital. He also pointed out that there are now 1000 more inmates in the workhouse than there were ten years ago. Upon a vote being taken the recommendation of the special committee was rejected. A resolution was afterwards carried that pavilions be erected in front of the Kirkdale site to provide for the sick poor now located in the attic wards. It may be mentioned that this huge workhouse contains about 4000 inhabitants.

Success of Liverpool Medical Students.

At the recent examination for the final M B. Victoria seven candidates from University College, Liverpool, presented themselves. Six of these were successful, two obtaining first class, and one second class, honours. The fact of all the honours being carried off by Liverpool students has given great satisfaction here, and is an indication of the rapid strides which this school has made since the endowment of the chairs of anatomy, physiology, and pathology, so ably filled by Professors Paterson, Sherrington, and Boyce. All these gentlemen have been unwearied in their efforts to bring the Liverpool School of Medicine well to the front.

Birkenhead Medical Society.

The annual dinner of this society was held on Saturday evening last, under the chairmanship of Dr. Harris, J.P., the President of the society. The dinner, which was of a *recherché* character, was enlivened by a delightful musical programme. Dr. Harris made an excellent chairman, and under the influence of his geniality of manner and witty speeches the evening passed off in a most enjoyable manner.

April 15th.

WESTERN COUNTIES NOTES.

(FROM OUR OWN CORRESPONDENT.)

Sad Death of Mr. John Miller Kirkman.

A VERDICT of suicide whilst temporarily insane was returned by the coroner's jury at the inquest held on April 9th upon the body of Mr. John Miller Kirkman, M.R.C.S. Eng., L.R.C.P. Edin., of Wootton Bassett, near Swindon, who committed suicide by cutting his throat with a razor and then taking hydrocyanic acid at Wootton Bassett on April 7th. Mr. Kirkman, who had lately complained of being overworked, should have attended the Quarter Sessions at Salisbury held on that day to give evidence in the case of a labourer at Swindon who was charged with attempting to commit suicide by cutting his throat. Much regret is felt by the inhabitants of Wootton Bassett, for Mr. Kirkman was a well known and much esteemed resident, extremely popular, and identified with all movements for the good of the town.

The Hospital Saturday Fund at Bristol.

The Mayoress of Bristol has lately received the ladies associated with the various hospitals of Bristol for the purpose of making arrangements for the successful working of the proposed Hospital Saturday. It was agreed that there should be a house-to-house canvass, as well as a street collection, and in order to carry this out efficiently a ladies' committee was appointed. It was thought that the villages round Bristol, which send many cases to the infirmary and hospital, should be included in the sphere of operations. The Hospital Saturday will in all probability be held in June. The Bristol people have of late had their attention called to the urgent need of their two great medical charities for increased support, for in spite of strict economy the committees of the Royal Infirmary and General Hospital have found their expenditure considerably exceed the annual income. Under these circumstances it is desired to make this year's Hospital Saturday productive of substantial results.

Lunacy in Somerset.

The visiting committee of the Somerset and Bath asylum, in their annual report, which was read at the quarterly meeting of the Somerset County Council held on April 7th, stated that the number of patients on the 31st of March, 1896, was 349 males and 522 females. There were 182 persons boarded out, 60 being at the Bristol City Asylum. The total number of patients, including those boarded out, was 1053, an increase of 24 over that on the same date last year. The patients at Wells were considerably in excess of the accommodation. The overcrowded state of the asylum rendered the administration difficult and hindered the medical treatment of the patients. The expenditure on account of the Western Joint Asylum was £81.168. It is hoped that there will be accommodation for 200 patients at the commencement of the new year in the new asylum.

The Jenner Society.

At the meeting of the Gloucestershire Standing Joint Committee held on April 7th the chairman (Sir J. E. Dorington) laid before the committee Dr. Bond's proposal to form a Jenner Society, and said that the only way to check the dissemination of mischievous views which were contrary to all scientific knowledge was by putting the public right, and it was proposed with this object to start a Jenner Society in Gloucestershire which they hoped might spread throughout England and counteract the mischief wrought by the Anti-Vaccination Society. The Lord-Lieutenant (Earl of Ducie) was willing to become president, the Dean of Gloucester chairman of the executive committee, with Mr. Lloyd Baker as honorary treasurer and Dr. Bond as honorary secretary, and he hoped a good start would be made that day and that they would get members in Bristol and Cheltenham and grow to be a great society. Twenty-one gentlemen had already signed as willing to become members. The vice-chairman and several other gentlemen expressed themselves as thoroughly in sympathy with the proposition. The chairman also said that three cases of small-pox had occurred in the county asylum, where there were over 1000 patients and nearly 200 attendants, but the whole of the patients and attendants were at once vaccinated, and the disease was stayed.

The University College of South Wales and Monmouthshire.

The total subscriptions promised up to the present for the

new building fund of the University College of South Wales and Monmouthshire amounts to over £16,000. This is a most encouraging response to the appeal which was recently made at a public meeting, but as the condition of the Treasury has to be fulfilled by July next there still remains a considerable sum to be collected. Mr. Louis Tylor, the treasurer of University College, confidently anticipates that this sum will be raised. The Treasury has authorised the payment of £10,000 to the building fund, this being half the sum promised by her Majesty's Treasury on condition that £20,000 was collected in South Wales and Monmouthshire.

Death of Mr. David Thomas of Llandovery.

Mr. David Thomas, J.P., M.R.C.S. Eng., L.S.A., died at his residence, Mile End House, Llandovery, Carmarthenshire, on March 31st, in his eighty-second year. Mr. Thomas took the qualification of M.R.C.S. in 1838, and the L.S.A. a year later. Deceased, who was extremely popular in the town, had retired from practice for some years. He had been connected with the Llandovery Corporation for many years, and at one time filled the office of mayor. Mr. Thomas was formerly assistant surgeon to the Royal Carmarthenshire Rifle Volunteers, and was a justice of the peace for the county. The funeral took place on April 4th, at Llandingat Church, Llandovery, amidst general tokens of sorrow and esteem.

April 15th.

SCOTLAND.

(FROM OUR OWN CORRESPONDENTS.)

Edinburgh Royal Infirmary.

AT a meeting of the managers held this week Mr. John Walcot presented an interim report by the house committee on the state of the fire appliances in the infirmary. In the report it was recommended that the more urgent of the suggestions made by the firemaster should be at once carried out at an estimated cost of £83 and that the infirmary should be connected with the police office by a special telephonic wire. The report was approved.

Bequests by the Earl of Moray.

In allocating the sum of £50,000 bequeathed by the late Earl of Moray to the city of Edinburgh, county charities, and other institutions, his trustees have apportioned the sum of £20,000 to the University Court of the University of Edinburgh as an endowment for the promotion of original research in the University, £3500 to the Sick Children's Hospital, £2500 to the Leith Hospital, £2000 to the Longmore Hospital for Incurables, £1000 to the Chalmers' Hospital, £1000 to the Church of Scotland Deaconess's Hospital, £500 to the Victoria Hospital for Consumption, £500 to the Maternity Hospital, and £100 each to the New Town and Western Dispensaries, the Dental Hospital, and the House of Refuge.

Edinburgh University Graduation Ceremonial.

At the spring graduation ceremonial, which took place on the afternoon of Saturday, April 11th, Principal Sir William Muir, Vice-Chancellor of the University, being in the chair, one of the four gentlemen presented by Professor Sir Ludovic Grant for the honorary degree of LL.D. was Dr. Douglas Argyll Robertson. The address to graduates was delivered by Professor Prothero, who occupies the Chair of History in the University.

Opening of the Royal Observatory, Edinburgh.

The new Royal Observatory on Blackford Hill, Edinburgh, was formally opened on Tuesday, April 7th, for the teaching of astronomy on University lines. Lord Balfour of Burleigh, Secretary for Scotland, performed the ceremony of declaring the Observatory opened. Among those present were the principal and many of the professors of the University, as well as a large number of ladies and representatives of scientific societies throughout the country. The Astronomer-Royal for Scotland, Professor Copeland, read an interesting account of the history of the Observatory, and the architect, Mr. W. W. Robertson, gave an explanation of the reason of some of the architectural arrangements. The observatory is furnished to a large extent by the astronomical instruments and library presented to the nation a few years ago by Lord Crawford.

Deputy Commissionership in Lunacy.

Lord Balfour of Burleigh, Secretary for Scotland, has appointed Dr. Charles Macpherson, Bonar Bridge, to be a Deputy Commissioner in Lunacy for Scotland in place of the late Dr. Lawson. Dr. Macpherson is a graduate of the University of Glasgow and is medical officer to the Sutherlandshire Combination Poor-house.

The Case of Mr. Stocks.

The extraordinary treatment that has been experienced by Mr. G. M. Stocks will require, surely, some public explanation.

Glasgow Royal Infirmary.

Dr. J. W. Allan has been appointed dispensing physician to the Glasgow Royal Infirmary in place of Dr. Auld, resigned. Dr. Allan's promotion leaves a vacancy on the staff of the extra dispensary physicians.

Public Health Scotland Bill, 1896.

The corporation of Glasgow has drawn up a memorial on the subject of this Bill suggesting a number of additions and alterations. It is especially pointed out that many of the provisions of the Local Police Acts go further than those contained in the proposed Bill. The corporation are advised that the powers they thus possess would be interfered with in so far as these were in excess of those granted under the new Bill should it became law. Hence they suggest the insertion of a clause to prevent such interference. In particular it is instanced that the capacity of the authorities to deal with infectious diseases, school attendance and infectious diseases, supervision of dairies, &c., will be lessened unless such a clause is inserted in the Act. With regard to the section of the Act dealing with the inspection of dairies and which authorises such inspection by the medical officer only under an "order of the magistrate, justice, or sheriff," whilst examination of the cows is only to be undertaken if the medical officer is accompanied by "a veterinary inspector or some other properly qualified veterinary surgeon," the memorialists submit that these provisions are a most inopportune decline from the power of inspection already possessed by the Glasgow authorities by which the medical officer or sanitary inspector can at any time enter any byre or cow-shed if the milk obtained therein is being sent for sale within the city. The memorialists also object to the clause making the inspection of the cattle contingent upon the presence of a properly qualified veterinary surgeon. They insist that this is unnecessary as the detection of those conditions in cows which render the consumption of their milk dangerous can be made, and indeed was in the first place made, by medical men; they doubt too whether it would be possible in many counties to find a properly qualified veterinary surgeon to act with the medical officer.

The Health of Dr. T. B. Russell of Glasgow.

Dr. Russell's convalescence has not been quite so rapid as was anticipated, and he has applied to the Health Committee for a month's further leave of absence from his official duties.

The New Infirmary Scheme, Paisley.

The directors of the Paisley Infirmary are now in a position to proceed with the erection of the new infirmary according to the original plans. These plans involved the construction of three pavilions, but the estimates being much in excess of the amount anticipated it was decided to limit the building to two pavilions. The directors have, however, lately received information that the full amount—about £10,000—required for the third pavilion has been raised, and they have therefore decided to proceed with the original scheme. It is understood that the gentleman who has been mainly instrumental in obtaining the sum required is Mr. Peter Coats, himself a handsome subscriber to the scheme as well as the donor of the Nurses' Home.

University of St. Andrews and University College, Dundee.

The relations between the University of St. Andrews and the Dundee College do not improve, and the position appears to become more and more complicated. The Secretary for Scotland, who has been appealed to, feels himself precluded from interfering as long as litigation between the University and the College is going on. There is a party in the University Court determined apparently to keep Dundee outside the academic circle, and in pursuit of this policy an endeavour is to be made to equip St. Andrews with teaching in medical and scientific subjects. Thus, though the Universities' Commissioners have reported against the proposal, it was decided

at the last meeting of the University Court to establish lectureships in anatomy and materia medica at St. Andrews. The motion was carried by the casting vote of the chairman—the Marquis of Bute.

Montrose Asylum.

At the monthly meeting of the board the report of Dr. Sibbald, Commissioner in Lunacy, was read. It indicated complete satisfaction with the management and arrangements of the asylum.

April 14th.

IRELAND.

(FROM OUR OWN CORRESPONDENTS.)

"The Hospital for Incurables."

UNDER the above title a long series of letters have recently appeared in the daily journals of Dublin in reference to the action of the visiting committee of governors in dismissing two of the inmates for impertinence. The editor of the *Irish Times* is addressed by one who signs herself a "Lady Life Governor," and who complains bitterly of the injustice involved in such a severe punishment for such a comparatively small offence. She is subsequently attacked by one of the governors, a J.P. and town councillor, and accused of hysterical exaggeration, of misplaced sympathy, &c., and described in a rather sneering fashion as an example of the type of lady Poor-law guardian recently enfranchised in Ireland by Parliament. She and the other lady governors of this large and admirably managed institution have, however, found a champion. A moderate and sensible letter has appeared from Judge Kane stating that he, as one of the visiting committee, made a careful investigation into the case of the two women, both of whom had been insubordinate and impertinent to the lady superintendent, and therefore deserved punishment. The learned judge, however, goes on to say that the punishment which was inflicted was in his opinion "harsh, uncalled-for, and utterly disproportioned to the offence." He concludes by paying a high compliment to the lady governors for their special and invaluable services to the hospital. The whole occurrence will afford a lesson to a certain section of the governors of this great charity and perhaps serve to remind them that there are occasions when justice may be suitably tempered with mercy.

The Sale of Food and Drugs Act.

A curious case came before the Recorder of Belfast on April 8th. It was an appeal from the magistrates, who fined a man £3 and costs, or in default a month's imprisonment, in an action brought under Section 6 of the Sale of Food and Drugs Act, with reference to the sale of what is known as linseed cake meal. The meal had been sold to the inspector under the Food and Drugs Act, and when submitted to the public analyst he found it adulterated with 30 per cent. of farinaceous matter. For the defence it was urged that linseed meal and linseed cake meal were different substances, and that linseed meal practically could not be procured in an absolutely pure condition, and that linseed cake meal was not a drug within the meaning of the Food and Drugs Act. In giving his decision the Recorder said linseed meal appeared to be used for two purposes—feeding cattle and for human purposes. If for the former the 56th and 57th Victoria protected the purchaser, because it provided that an invoice should be given. This had not been done in the above case, and hence he must assume that it was not sold for cattle. If this was not done the seller had been guilty of an offence under the Act he mentioned (56th and 57th Victoria). It was used in medical practice, but it appeared that owing to its adulteration the faculty were giving up its use. That prosecution was to put an end to that. It had nothing to do with the selling of linseed cake for the purpose of cattle feeding nor had he (the Recorder) anything to do with that question. The prosecution was for selling linseed cake meal as such, and the opinion of one witness produced by the defendant was that it was not the article for which it was sold. Could anyone have a doubt when it was used for human purposes that it was a drug? He thought the magistrates had acted properly in convicting in that case, and he would confirm their decision, with costs.

Proposed Sewerage Scheme for Portadown.

The town commissioners of Portadown have for some time been anxious to abate a serious nuisance existing in a part of that town, and they adopted a scheme; but as it was proposed by it to empty the sewage into the River Bann, which is contrary to the Rivers' Pollution Act, the Local Government Board refused to advance the money (£1200) necessary to carry out the work. On April 8th, at a meeting of the commissioners, the matter was again very fully considered, when the town clerk read a letter from two civil engineers suggesting three possible solutions of the difficulty. After considerable discussion the board decided to defer its decision for a time, and appointed a sub-committee to confer with the engineers for the purpose of ascertaining whether any better arrangement could be adopted. Portadown is a very difficult place to arrange a sewerage scheme; for it is situated in a very flat district with the River Bann flowing through on its way to Lough Neagh. It is contrary to law to empty sewage into this river, and owing to there being no fall any other satisfactory plan is hard to devise.

The Winter Session, Belfast.

The winter session came to an end this week at both Queen's College and the hospitals. The medical examinations of the Royal University will begin on April 28th and the summer session at Belfast will commence at the beginning of May.

The Coroner and the Sanitary Authorities.

A matter which has never before arisen in Belfast came before the coroner's court on April 13th. It seems that the coroner considered it necessary to hold an inquiry in reference to the death of a child which had resulted from measles—a disease at present epidemic in some districts of Belfast. As the coroner did not want to subject the jury to the necessity of going into the house where the deceased child was lying and possibly carrying the disease to their children and families, and as he did not wish to put the police into the position of touching the body, as they also might convey the disease to their families, he requested the police to ask the sanitary authorities to have the body conveyed to the room specially fitted up in the new morgue for the purpose of depositing bodies of persons who died from infectious disease. The sanitary authorities replied that they had no power to do so, and accordingly the body was not removed. The jury not having seen the body of the child they could not hold an inquest. The coroner adjourned the inquest for a day and sent a formal application to the sanitary authority to have the body removed. The coroner said he was bound to send a report to the Lord Chancellor, and in case the sanitary authority did not carry out this order, and he exercised the same right as a magistrate, he would write to the Local Government Board. The section of the Public Health Act referred to by the coroner (the 158th) contains the following: "Where the body of one who has died of any infectious disease is retained in a room in which persons sleep or live, or any dead body is in such a state as to endanger the health of the inmates of the house or room is retained in such house or room, any justices may, on a certificate signed by a legally qualified medical practitioner, whose fee for giving the certificate shall be one guinea, to be paid by the sanitary authority, order the body to be removed at the cost of the sanitary authority to any mortuary provided by them, and request the same to be buried within a time to be limited in such order." At an adjourned inquest held on April 14th it was reported that the sanitary authorities had removed the body to the morgue. After hearing the evidence the coroner, in summing up, said that at the last meeting of the corporation the Lord Mayor had expressed his dissatisfaction at the high death-rate of the city—30 per 1000. He (the coroner) trusted some steps would be taken to try to reduce this rate. Unfortunately the sanitary authorities of Belfast had not adopted the Notification of Diseases Act, although most of the leading cities in the empire had. Measles was now prevailing in Belfast, and yet no steps had been taken to isolate such cases because the sanitary authority had no power to isolate them. The jury, in their verdict, said that the case clearly proved the necessity for the adoption of the Notification of Diseases Act by the corporation.

April 15th.

ROYAL INSTITUTION.—Dr. Poore is to deliver the Friday evening lecture on April 24th, at 9 P.M., on the Circulation of Organic Matter.

PARIS.

(FROM OUR OWN CORRESPONDENT.)

The English Language and the Moscow Congress.

As was to be anticipated, the managers of the forthcoming International Medical Congress have given way on the language question. Communications may therefore be read in French, Russian, German, and English, the first-named remaining the only official language, whatever that may mean. The protests of Dr. Fränkel of Berlin and Dr. Felix Semon of London have likewise borne fruit, and a special section devoted to Laryngology will accordingly be instituted.

Death of Dr. Constantin Paul.

It is not long since the distinguished therapeutist Dr. Dujardin-Beaumetz was removed from our midst, and now another scarcely less renowned authority on therapeutics has joined the majority. Dr. Paul died on Sunday last from albuminuria at the comparatively early age of sixty-three. Appointed *agrégé* of the Paris Faculty in 1866, he became successively physician of the St. Antoine, Lariboisière, and Charité Hospitals, and was elected a Member of the Academy of Medicine in 1880. He took a special interest in diseases of the heart, and in 1883 he published a work that was widely read, entitled "Diagnostic et Traitement des Maladies du Cœur." But general therapeutics were his favourite study. In 1876 he helped to bring out a new edition of the once universally consulted "Traité de Thérapeutique et de Matière Médicale" of Trousseau and Pidoux. His communications on the action of drugs were numerous, no discussion on such a subject at the Academy of Medicine being considered complete without a pronouncement from him. This year he was elected president of the Société de Thérapeutique, and last year in the Fête Nationale (July 14th) the Cross of the Legion of Honour was publicly pinned on his breast in the courtyard of the Hôtel Dieu by the President of the Republic. Dr. Paul leaves one son, a well-known artist.

The Balsam of Peru Treatment of Scabies.

Dr. Jullien and Dr. Descouleurs call attention[1] to the advantages of the above non-sulphurous treatment of itch, their conclusions being based upon 300 cases observed both in private and hospital practice. It is known that the acarus placed on a watch-glass and exposed to sulphur fumes may remain alive for sixteen hours, and that it generally survives over an hour's immersion in flower of sulphur and Helmerich's ointment. Dr. Descouleurs placed six in contact with balsam of Peru and found that in ten minutes two were dead; in twenty minutes three more had succumbed; and the last of the six died soon after. This experiment confirms the conclusions of Burchardt, who, moreover, discovered that the balsam kills the eggs as well. It is probable that the volatile oil—cinnamein—that according to Frémy is the essential constituent of the balsam, kills the acarus at a distance through asphyxia and not through a corrosive action or by disruption, for Hebra has shown that the parasite can live for a week in water at 30° C., and Dr. Descouleurs has witnessed survival for three and a half hours in glycerine. The application of the method is simplicity itself. No soap is required, the balsam being painted on the surface and then gently rubbed into the whole body with the hand. The remedy being volatile penetrates readily into the "runs" without involving the necessity of opening these up. The patient remains thus all night, a warm bath being taken in the morning, when the cure is said to be complete. A repetition of the process, if necessary, produces no irritation of the skin. Inveterate cases that had resisted the classical and rather severe *frotte* at the St. Louis Hospital were all invariably cured by this method, which would seem to be specially indicated when scabies is complicated with impetigo, eczema, ecthyma, and boils, and also in cardiac cases, pregnant women, and feeble subjects with delicate teguments—e.g., babies. The rather agreeable odour of the balsam tells greatly in its favour, especially in private practice. Dr. Feulard stated that he has used it for some time in the form of ointment at the Children's Hospital, where he also successfully employs it against seborrhœic eczema of the scalp and impetigo.

April 14th.

[1] Société Française de Dermatologie et de Syphiligraphie, April 10th.

ROME.

(FROM OUR OWN CORRESPONDENT.)

The Health of Italy in 1895.

THE Commendatore Bodio, Director-General of Statistics for the Italian Kingdom, has drawn up a singularly clear and instructive memoir on the social condition of Italy in 1895. Beginning with the population, he tells us it increases steadily by an excess of births over deaths equal to 10 per annum for every 1000 inhabitants. The same proportion obtains in England (not in Scotland or in Ireland), in Germany taken as a whole, and in the Scandinavian countries, while in France the population still continues stationary, if, indeed, in some years the deaths have not actually exceeded the births. As to the sanitary condition of the kingdom, Signor Bodio contents himself with signalising the causes of death. Mortality from infective diseases (as, indeed, has been noted in THE LANCET) has for several years been on the wane. From small-pox 16,249 died in 1887, as compared with 2606 in 1894. Typhoid fever, which numbered 27,800 victims in 1887, counted no more than 13,639 in 1894. But, on the other hand, there has been a sensible increase in the deaths from bronchitis, pneumonia, enteritis, nephritis, &c., so that the total mortality is about the same as before. "This means," according to Signor Bodio, "that the poor population which fares badly, if even rudimentary precautions of hygiene are to-day a little less openly defied than before the sanitary service of the communes was enlarged and reorganised, is more severely decimated by the ordinary causes of death, which find their natural prey in organisms enfeebled and ill-provided with resisting power." The demonstration of the improvement attained is most evident in the city of Naples, where good potable water has replaced that of the wells sunk in the subsoil. Here Signor Bodio's figures are sufficiently eloquent. Typhoid fever, which numbered 468 victims in 1881, counted but 173 in 1893. The section on superior or professional education is full of interest. The excess of "avvocati" (barristers), a class which swells the ranks of professional politicians, not to say agitators, and is far too greatly represented in the Legislature, is still an evil to be deplored. The average per annum of "laureati in legge" (graduates in law) is, according to Signor Bodio, 1000, while those who can possibly make a livelihood out of it are about 500. Not only so, but the residual 500 of each previous year has to be counted in till the country literally swarms with "legal unemployed," who take refuge in journalism, platform propagandism, and every sort of political and social movement. Less to be lamented is the over-production of "laureati in medicina," for even if they do not practise they diffuse and raise the standard of that best of all knowledge—that which makes a man "the intelligent custodian of his own health." Still, the profession is greatly overstocked in Italy, with the inevitable result of a not always healthy competition. There are in the kingdom 66 practitioners for every 100,000 inhabitants, while in France the proportion is 40, in Austria 34, and in Prussia 32.

Professor Maragliano's Anti-Tuberculous Therapeutics.

The Ligurian Medical Congress has just been sitting at San Remo, and its most interesting feature has been Professor Maragliano's paper on Tubercolosi Latente e Tubercolosi Larvata (Tuberculosis Latent and Masked). He insisted on what Dr. Edward S. Smith pointed out some fifty years ago on the "pretubercular stage" and elaborately particularised the indications which precede what he described as the "explosion of tuberculosis." It is at this stage that sero-therapy has most chance of success, and therefore its diagnosis, from the point of view of his own therapeutics, is of primary importance. Carefully graduated injections of "tuberculina" he showed to have a special and valuable diagnostic power in determining the existence of the "stage" in question. He was followed by Professor Lucatello, who gave the results of 492 cases of tuberculosis treated on the Maragliano system by Italian practitioners. All these cases were well marked, most of them grave, but after the serum injections as many as 90 per cent. showed diminished pyrexia, arrest of pulmonary lesion, and increased weight of body. These results exceeded the expectations of Professor Maragliano himself. The two memoirs (Maragliano's

and Lucatello's) will shortly appear in the official "Atti" and cannot fail to interest the profession.

April 11th.

VIENNA.

(FROM OUR OWN CORRESPONDENT.)

Trional.

DR. DRESS has published in the *Medicinische Presse* an article on trional in which he claimed for this remedy advantages not possessed by other hypnotics. On account of its solubility it acts more quickly than sulphonal, and it produces a sleep which lasts from six to eight hours and is seldom followed by unpleasant symptoms. In one case a cumulative effect was observed, the explanation being the bad condition of the patient. Trional has no disadvantageous influence on the disintegration of albumin in the organism, thereby differing from chloral hydrate, which affects both the heart and bloodvessels. According to Dr. Dress the dose should not exceed 2 grammes (= 31 grains). Sleep of eight hours' duration may be obtained in all cases where wakefulness is due to pain, but in neurasthenic sleeplessness a dose of 1 gramme (= 15½ grains) is sufficient. Trional must not be taken dry, but always with about 100 c.c. (= 3½ fluid ounces) of warm liquid, and the patient may drink mineral waters in order to increase the alkalinity of his blood. Dr. Dress has employed trional in 30 cases, including 19 adults and 11 children. In the adults the sleeplessness was due in one case to neurasthenia, in 2 to hysteria, in 1 to phlegmon of the hand, in 3 to arthritis, in 3 to lumbago, in 1 to prurigo, in 1 to neuralgia of the fifth nerve, in 1 to the results of a burn, in 2 to intercostal neuralgia, in 1 to carcinoma of the womb, and in 3 to pulmonary phthisis. Among the children it was due to otitis in 3 cases, to meningitis in 1 case, to night-terrors in 2 cases, to chorea in 1 case, to enteritis in 2 cases, to pneumonia in 1 case, and to furuncle of the ear in 1 case. For the adults the dose varied from 1 gramme (= 15½ grains) to 1·5 grammes (= about 23 grains), and for children from 0·2 gramme (= about 3 grains) to 0·8 gramme (= 12 grains). In 28 cases sleep occurred after twenty minutes, but in 2 cases—those of phlegmon and enteritis—it came on only after three hours, and the patients complained of giddiness, tinnitusaurium, and nausea. In these instances the drug had not been taken in the manner directed.

"Pseudo-hemisystolis."

At a meeting of the Medical Society of Prague Dr. Hering described the case of a female patient who had been admitted to the hospital with insufficiency and stenosis of the mitral valves and insufficiency of the tricuspid valves. The apex beat was in the sixth intercostal space, the radial pulse was frequent, irregular in rhythm and intensity, and very small. There was also pulsation of the jugular and subclavian veins and of both saphenous veins, the venous pulse alternating with the arterial. Dr. Hering has named this state "pseudo-hemisystolis." Though the occurrence of this condition has not hitherto been satisfactorily ascertained, it may nevertheless be supposed that under pathological circumstances the contraction of both ventricles does not take place at the same time. The temporary decrease of the volume of the pulse may be due to both the acceleration of the heart's action and to the trifling quantity of blood in the arteries, whereas the venous pulse is produced by the fact that owing to the insufficiency of the tricuspid valves a quantity of blood is driven back into the auricle during each systole of the right ventricle, and thus a wave is produced in the venous trunks.

Female Medical Practitioners.

The Minister for Public Instruction has just issued a decree relative to the recognition of diplomas obtained by women from foreign universities. In order to be admitted to practice in Austria the female candidate must be an Austrian citizen and must be at least twenty-four years of age. She must also have passed the full examination (Reifezeugnis) of an Austrian gymnasium and must have attended a five years' course in a medical school, the requirements of which are equal to those prevailing in Austrian universities. In every case the professors of the university to which the candidate will be admitted have to decide the question of her admission and the result is to be reported to the Ministry. If admitted the candidate is required to pass all the examinations with the exception of those in zoology, botany, and mineralogy.

Death of Professor Josef Spaeth.

Professor Spaeth, the celebrated Vienna obstetrician, died on March 29th in the seventy-third year of his age and about ten years after he had retired from academical life. He was born at Bozen, in the Tyrol, in 1823, was appointed assistant at the School of Midwifery in the Josef Academy in 1855, was promoted to the ordinary professorship in 1856, and in 1873 became chief of the obstetrical clinic, where he remained until 1886. From the long list of his scientific works I need quote only his "Clinical Gynæcology and Midwifery," "Outlines of Gynæcology," and "Text-book of Obstetrics for Midwives." In 1872 he was elected rector of the university. Professor Spaeth was not only an excellent teacher, but also a benevolent man, who practically exemplified his principles by bequeathing his entire fortune to the Society of Sick Students. The funeral was attended by a great many leading medical men, and his pupil, Professor Schanta, eulogised the merits of the deceased.

The Salaries of Medical Teachers.

According to a Bill which has just been submitted to Parliament the Government intends to augment the salaries of the professors. Hitherto there have been three scales—namely, £180 a year for the professors in Vienna, £166 for those in Prague, and £155 for those in other towns, the professor also receiving fees for his lectures. In Austria lectures are delivered five times a week and the fees are fixed at 10*s.* 6*d.* a half-year. Teachers have now the choice between the above salaries with the fees for lectures and the augmented salary, with gratuitous lectures, which has been fixed at £266, £300, and £333. "Extraordinary" teachers will be paid £133 and the *privat-docents* will be unpaid as hitherto.

April 12th.

RUSSIA.

(FROM OUR OWN CORRESPONDENT.)

The Moultan Murder and the Votiaks.

No medico-legal case of recent years in Russia has given rise to so much discussion and to so many and such diverse expressions of opinion as the trial and sentence of seven Votiaks for what is generally spoken of as the Moultan murder. Although the events which led to the trial occurred four years ago the matter is still as hotly discussed as though they had happened yesterday, in this respect resembling an equally notorious case at home. The intemperate expressions of opinion over the sentence on Mrs. Maybrick (a sentence passed nearly six years ago, and yet even now the subject of controversy in England and of interpellations in the American Senate) find their exact analogue in the articles and letters to the press which attempt to re-try the convicted Votiaks sentenced for the Moultan murder. The facts of that murder may be briefly stated. On May 6th (18th), 1892, the dead body of a Russian peasant was found in a marshy spot near the village of Moultan, in the government of Viatka (in European Russia). The head had been cut off from the body and was not found; several dorsal vertebræ had been removed so as to enlarge the opening into the thorax, and through this opening all the thoracic viscera had been extracted. There was some evidence to show that the victim had been suspended head downwards before life was extinct, in order to collect the blood flowing from an opening made into the abdominal veins. These circumstances led the authorities to conclude that the murder had been committed with a religious object, and that the blood and viscera had been thus obtained for the purposes of some rite of the nature of a sacrifice to heathen deities. Seven men, mostly but not all Votiaks, were tried and sentenced to varying terms of imprisonment. The case was tried a second time on appeal, but without affecting the result, and the convicted, or those which survive (for some are stated to have died since the trial), are now working out their sentence. The case is one of the highest medico-legal interest, but it would be impossible here to even mention the countless points which have led to discussion and to the formation of most opposite opinions even by experts. These points may be roughly classified as medico-legal and ethnological or anthropological. In the last number of the *Vratch* Professor Bellin sets out at

full length the medico-legal points, and comes to the conclusion that the necropsy was made so long (one month) after the murder that even the cause of death could not be ascertained, and his opinion is that the murder was an ordinary one and that the removal of the head and viscera was accomplished some days after death with the object of throwing suspicion on the Votiaks, who have frequently been charged with offering human sacrifices. The ethnological evidence on this last point is equally conflicting. M. Korolenko, a well-known writer, recently read a paper on this subject at a meeting of the Anthropological Society in the Academy of Medicine. He came to exactly the same conclusion, and further stated that no charge of human sacrifice had ever been substantiated against the Votiaks. On the other hand, a M. Poplavski, in an article in a lay paper, quotes several instances occurring in the last two decades where the evidence of human sacrifice was certainly very strong, if not conclusive, and mentions people now living who could corroborate his statements. Altogether the question is not unlike that of the charges of murder of Christian children brought against the Jews in the middle ages, and even now revived occasionally in some highly anti-Semitic corners of the Continent. Unfortunately no miraculous *alma redemptoris* broke from the dead lips of the murdered Russian peasant at Moultan to set at rest for ever the secret of his fate. It would be idle to speculate on the nature of that secret. In the presence of conflicting statements on both sides, and in the absence of the detailed evidence, which, however, twice satisfied the Russian courts of justice as to the guilt of the accused, it is impossible to form an unbiased opinion.

The Russian Ambulance Corps for Abyssinia.

The ambulance corps organised by the Russian Red Cross Society to proceed to Abyssinia in aid of the sick and wounded Abyssinians left St. Petersburg last week. A large crowd collected at the station and loudly cheered the expedition as the train started. Telegrams from Odessa announce the safe arrival there of the corps, and before these words appear in print it will be well on its way to Port Said, whither it is being conveyed on board the volunteer steamer *Rossia*. The expedition consists of ten medical men, six *feldschers*, twenty sisters of mercy, three agents, and one priest, and it is well supplied with provisions sufficient for three or four months. The Italians have consented to allow the expedition to pass through their African territory. Next week a similar but smaller corps is to be sent by the same society to Naples to aid in nursing the invalided Italians.

April 13th.

PHILADELPHIA.

(FROM OUR OWN CORRESPONDENT.)

The University of Pennsylvania.

THE medical faculty of the University of Pennsylvania recently submitted a recommendation to the board of trustees of the University to the effect that, beginning with the year 1896, the entrance requirements of the medical department be increased, and, further, that they should be increased annually thereafter until 1899, by which time they will have become the same as those required by the department of arts. It is also proposed to make the tuition fee $200 instead of $150 per annum. The Harvard Medical Faculty have recently adopted a rule, to become operative in June, 1901, making it necessary for candidates to the medical department to have a degree in arts, science, literature, philosophy, or medicine from a recognised college or scientific school. An effort is being made to establish a fellowship in anatomy in the University of Pennsylvania as a memorial to the late Dr. Joseph Leidy.

Jefferson Medical College.

Dr. George Dock of Ann Arbor, Mich., having declined the chair of Pathology and Bacteriology in the Jefferson Medical College, it was tendered to, and accepted by, Dr. W. M. L. Coplin, a former demonstrator in the institution, but recently Professor of Pathology in the Vanderbilt University, Tennessee.

"Emotion Products."

The Biblical expression, "Though your sins be as scarlet," would seem to have some foundation in fact if we believe the claims made by Dr. Gates, who says that the various human emotions and passions, good and bad, result in the formation of definite secretions. These, circulating in the blood, act upon the brain and thus cause vice or virtue. He believes that they are excreted with the perspiration, in which they can be shown by chemical tests. He says he had isolated forty "emotion products." Vice and virtue give rise respectively to poisonous or beneficial products, "but the worst of all these secretions is that of guilt." Dr. Gates states that if some of the perspiration of a person "suffering from conscious guilt" be mixed in a test tube with a few drops of selenic acid a pink colour will result.

The New Photography.

Interest in the "x" rays seems unabated, judging from the frequent reference made thereto by the daily papers and the periodicals. Several enterprising tradesmen of this city have the apparatus at work in their shop windows, and popular lectures on the subject are being given for the benefit of churches and other institutions. Some very excellent work has been done by Mr. Goodspeed and Dr. Cattell, however. Dr. Dalley and Dr. Egbert have been experimenting with a view to finding whether or not the "x" rays exist in sunlight. They used an ordinary photographer's printing frame, in which was fitted a sheet of aluminium $\frac{1}{20}$th of an inch in thickness. Under this was placed a positive plate or lantern slide, and next a sensitive unexposed plate. The frame was then backed with lead foil and tightly closed. It was then exposed to sunlight for two hours. A fair negative was obtained, although slightly over exposed. The positive plate was next replaced by a negative one and the time of exposure reduced to one hour. A better picture than the first was obtained, but it was found that the best results were yielded by an exposure of twelve minutes. Other experiments were made in which the aluminium was replaced by cardboard, vulcanite, and black paper, giving fairly good results in each case. These experiments would seem to indicate the need of care in the making of plate holders.

Obituary.

GEORGE F. STAINTHORPE, M.R.C.S. ENG., L.R.C.P. EDIN.

THE death of Mr. Stainthorpe of Newcastle at his residence, Benwell Old Lodge, at the age of seventy-four, will be much regretted by a large circle of friends, private and professional. This highly respected member of the medical profession was a Hexham man by birth, and obtained the diploma of the Royal College of Surgeons of England in 1854. He was chosen as a lecturer to the old Newcastle School of Medicine, and in 1859 became L.R.C.P. Edin. He commenced practice in the western part of Newcastle, and as that end of the town developed his practice became proportionally large and important. He was a kind and capable medical attendant, with whom many of his patients formed bonds of permanent attachment, while a certain reserve of manner was noticeable in him only when dealing with strangers. Some ten years ago he removed from the neighbourhood of the Cattle-market to Eldon-square, and two years later he decided to retire. He was attended during a lingering illness by Dr. Thomas Stainthorpe of Hexham, his brother, and Mr. Richard Ellis of Rye-hill.

DEATHS OF EMINENT FOREIGN MEDICAL MEN.—The death of the following eminent medical man is announced:—Dr. L. Didelot, *Professeur Agrégé* of Physics in the Medical Faculty of Lyons.

LITERARY INTELLIGENCE.—A new and cheaper edition of "Home Nursing and How to Help in Cases of Accident," by Samuel Benton, L.R.C.P., M.R.C.S., &c., will be published next week by Messrs. Abbott, Jones and Co.—The Rebman Publishing Company, Limited, 11, Adam-street, Strand, have in the press for publication a serial work exemplifying the uses of the new photography in medical and surgical diagnosis, entitled "Archives of Clinical Skiagraphy," by Sydney Rowland.

THE

INTERCOLONIAL MEDICAL CONGRESS OF AUSTRALASIA, 1896.

FOURTH SESSION.

(FROM OUR SPECIAL CORRESPONDENT.)

THE fourth session of the Intercolonial Medical Congress of Australasia commenced at Dunedin, New Zealand, on Monday, Feb. 3rd, and closed on Monday, Feb. 10th.

Never in the history of medicine in New Zealand has so great a gathering of its followers taken place as that which the week following on Monday, Feb. 3rd, witnessed in Dunedin, the chief city of the South Island of the colony of New Zealand, and it speaks well for the spirit that animates our profession that men should flock from all parts of Australasia to interchange ideas, and to make the acquaintance of those whose names stand foremost in the ranks of medical science in those colonies.

The true keynote of the aims of these great medical congresses was struck by Dr. Batchelor, the President, in his opening address,[1] when he said that medical science is bound up closely with our own common humanity and that the people gladly acknowledge the benefits that it is daily conferring upon them. As showing the interest which the Government of New Zealand have taken in the Congress, it is worthy of note that that body has kindly promised to pay half the cost of publishing the transactions of the Congress.

It is impossible to estimate duly the labour entailed on the executive committee in the arrangements for the successful carrying out of the programme, which included also the social as well as the scientific objects of the meeting. The Congress met for the first time in New Zealand, so that we are not well experienced in Congresses, and the capacity of the authorities with regard to organisation was tested to the uttermost with a brilliant result. Dunedin may well be proud of the pleasant if arduous duty that she has had to perform, and it must be a great satisfaction to those who have devoted so much pains to secure the success of the Congress to know that it cannot but bear good fruit.

On the invitation of his Worship the Mayor of Dunedin (Mr. Wales) the members of the Congress partook of luncheon in the Choral Hall on the opening day, Monday, Feb. 3rd. The Mayor occupied the chair and was supported by his Excellency the Governor on his right and on his left by the President of the Congress, the Hon. Richard Seddon (Premier of New Zealand), the Hon. Mr. Grace, the Hon. the Colonial Treasurer, and many distinguished Dunedin citizens. In replying to the toast of the "Medical Profession" Dr. Batchelor heartily welcomed the visitors to Dunedin and emphasised the value of meetings of this nature.

One is vastly impressed with the value of these intercolonial congresses to all who thus gather together. Medical men are not as a rule apt to possess narrow conceptions of life and its duties, but even they are sometimes insular and parochial in their views and need occasionally to see other countries and rub shoulders with their professional brethren elsewhere. Our Australian *confrères* are to be congratulated on coming so far to assist us by their presence at the Congress. When they return home and tell their less fortunate stay-at-home brothers in Australia of the lovely scenery they witnessed in the lake district and the grandeur of the scene round about Mount Cook it will add to the misfortune of those who were not able to attend the Congress.

After the first morning the weather was glorious in the extreme. The air was keen and bracing, while the brightness of the sky and the clearness of the air which invested Dunedin during the Congress week was a marked contrast to the "heat wave" which drove so many away from Australia during this summer.

The whole business and pleasure of the gathering has been administered throughout with a cordial good fellowship truly representative of that spirit of hospitality which happily characterises all colonial peoples. The meeting took place in a city famed all over Australasia for its unbounded hospitality. Right well have the present citizens of Dunedin maintained their reputation in this respect, vieing as they did with one another in making social gathering after social gathering a series of huge successes.

GENERAL MEETING.

On Monday morning, Feb. 3rd, during a heavy downpour of rain, which gave way shortly after noon to truly lovely weather, the Fourth Intercolonial Medical Congress of Australasia began to assemble for the purpose of the enrolment of members in the Otago University Library. The members subsequently adjourned to the theatre associated with the University, where a general meeting of the Congress was held, about ninety members being present. The lecture-room presented an imposing sight as the members of the Congress rose to greet with acclamation the entry of Dr. Batchelor, the President, and Professor Scott and Dr. Barnett, the general secretaries.

The PRESIDENT thanked the members very kindly for the warm reception they had accorded to him. It was not his intention, he said, to make any lengthened remarks at that stage, but he felt it would be hardly gracious on his part to take the chair without attempting to express his heartfelt gratitude at the great honour which had been conferred upon him in his election to the important position of President. One felt grateful for honour of any kind, but those honours which came from his professional brethren were, he always thought, the very highest which could be conferred upon a professional man; and they had conferred on him the very highest honour the profession in Australasia could confer on one of their colleagues when they elected him to that important office. Certain deputies had been appointed by the various Governments. Mr. Springthorpe specially represented Victoria; Dr. Love, Victoria; Dr. Sprott, Tasmania; and Mr. James and Dr. Brown, New Zealand. There had also been a gentleman appointed by the Government of Western Australia, but his name had not yet been received.

Report of Executive Committee.

The report of the executive committee was then read and adopted. There were now on the roll of the congress more than three hundred members.

Dental Section.

The PRESIDENT mooted the desirability of adding a dental section to the congress and after some discussion it was decided "that the question of the establishment of a dental section be transmitted to the executive committee of the next congress with power to take action in the matter."

Contagious Disease Act.

Professor SCOTT (Dunedin) laid on the table a memorial from the Women's Christian Temperance Union of Victoria on the subject of the Contagious Diseases Act. After some discussion it was decided "that the memorial be referred to the public health section."

The Hon. Mr. GRACE (Wellington) placed on the table a number of important documents relating to the subject which had been forwarded to him from England—chiefly reports of parliamentary commissions and results of investigations.

An Intercolonial Medical Journal.

Dr. BARNETT (Dunedin) brought up the question of establishing an intercolonial medical journal. They had a small

[1] Published in THE LANCET, April 4th, 1896.

quarterly journal of their own and they knew also of the Australian Medical Gazette, the Australian Medical Journal, and the Intercolonial Medical Quarterly, but they were anxious to have one strong representative magazine for the whole of the colonies.

Mr. SYME (Melbourne) was also strongly of opinion that it was highly desirable that they should have in Australasia one strong united journal.

After considerable discussion it was decided by forty-two to twenty-six votes "that the Executive Committee of next session be invited to give special attention to this matter."

THE INAUGURAL CEREMONY.

The inaugural ceremony in connexion with the Congress was held in the Choral Hall in the evening and proved a brilliant success. Nearly all the members of Congress were present and a very large number of distinguished ladies and gentlemen from all parts of the colony; in fact, the hall was so packed that there was scarcely standing room left.

His Excellency the Governor, Lord GLASGOW, was received with great enthusiasm and declared the Congress open. In the course of his remarks he said: I believe that you are, nearly all of you, aware that this is one of a series of Congresses which have been held during the last few years in Australasia. The first was held in Adelaide in the year 1887, the second in Melbourne in 1889 (the year of the great exhibition there), the third was held in Sydney in the year 1892, and this is the fourth of the series. I may point out that Dunedin is a town of 40,000 inhabitants, whereas Melbourne is a town of nearly 500,000 inhabitants and Sydney of 450,000. On behalf of New Zealand I may perhaps be allowed to say that it gives us great pleasure to think that so many medical men have come over and have paid this visit to our lakes, because we feel sure that when they return to their country they will say there is no place where it is more delightful to spend a hot summer than in the lake country of New Zealand. I think the medical profession of Australasia are to be congratulated upon having formed this corporation, if I may use the expression, and of having undertaken to meet together in this series of congresses as they have been doing for the last few years. This nineteenth century is a century which is remarkable for many things: I think among other things it is remarkable for being a century of congresses. On every possible subject people meet together to talk it over, and there can be no possible doubt that in all scientific bodies it is of the utmost use that the members should meet together and talk over the subjects in which they are interested. We all know that this is the case with the Royal Society at home, and with the different associations connected with science, and we are to be congratulated on the fact that the great medical bodies in these colonies are not behindhand in taking an interest in their work, but have met in the same way as they do at home for the purpose of talking over the work in which they are engaged. I think it is hardly necessary for me to assure the members of the Medical Congress of the interest which the public of New Zealand take in their work. I do not think there are many medical men in the world who are fitted to do their work if they are not the friends of those among whom they practise. You are all centres of groups of friends, and it is through your friendship with them that you are able to do your work efficiently. It is because in this colony, as in the others, we are well acquainted with the usefulness of the work you are here to do and the way in which you do it that we heartily show our interest in the work you have assembled to do, and wish you Godspeed in it. I now beg, Mr. President, to declare this Congress, the Intercolonial Medical Congress of Australasia, open, and to wish it Godspeed in its work.

The Premier of New Zealand (the Hon. RICHARD SEDDON) then welcomed the visitors to New Zealand, and the President read the inaugural address on the Present and Prospective Conditions of Medical Education, which was published in THE LANCET of April 4th.

THE SECTIONS.

The work of the sections began on Tuesday, Feb. 4th.

MEDICINE.

PRESIDENT'S ADDRESS.

Mr. HAYWARD read the presidential address, prepared by Dr. A. A. Lendon of Melbourne who was unable to come to the Congress. The author of the paper invited attention to the question as to the share which the general practitioner takes in the advancement of medicine, as contrasted with the work effected by those who devote themselves to some special branch of their art. What has the general practitioner achieved in the past, and what might he be expected to accomplish in the future? It was a matter of general belief that most, if not all, the advances of medical science emanate from those who are working in the more populous centres, and in a great measure that belief was justified; but general practitioners were not, and ought not, to be merely middlemen engaged in retailing the benefits discovered by those who have greater opportunities for carrying on investigations in the ward or in the laboratory; that they have independent functions and ample opportunities for exercising them in everyday practice; and that they might—nay, ought—to assist in defining the principles and in improving the practice of medicine. The best answer to the first part of the question propounded immediately presented itself, the year 1896 being the centenary of a very great event—the introduction of vaccination by Edward Jenner. "Jenner was attracted to the study of this question by a tradition which was prevalent amongst the dairymaids. When he was an apprentice a young countrywoman's statement that she could not acquire small-pox as she had already had cow-pox riveted his attention. Jenner mentioned this notion to Hunter who publicly alluded to it in his lectures and encouraged his pupil to investigate its truth when he returned to the country. Jenner set to work and collected several cases of persons who, having had cow-pox by accidental inoculation, were found to be insusceptible of inoculation with small-pox virus. He next studied the disease of the cow and he came to the conclusion, since generally thought to be erroneous, that the cow-pox arose from a disease of the horse known as the 'grease,' and he further concluded that this disease had to be transmitted to human beings through the cow, otherwise it had not the protective virtue, for men who contracted sores on the fingers from attending to horses with greasy heels were easily inoculated with small-pox; these sores were therefore probably ordinary septic processes. Jenner ascertained further that milkers might have cow-pox more than once. The chief objection raised by those to whom Jenner first announced his opinion was that occasionally instances of small-pox occurred after accidental inoculation with cow-pox, so that the rule could not be absolute; moreover, those who had had small-pox were not exempt from taking cow-pox. Thus foiled Jenner set to work again and demonstrated that all the sores met with on the udder of the cow were not true cow-pox, and, further, that it was only in a certain stage of the development of the vesicle that the true virus of cow-pox could be communicated so as to be protective against small-pox. Milkers were liable to contract sores on their fingers which were not true cow-pox. In 1796 the climax was reached. A girl named Sarah Nelmes contracted cow-pox on her hand, and on May 14th Jenner inserted some of the matter taken from the vesicle into two superficial incisions on the arms of a boy named James Phipps. Six weeks later matter from a small-pox pustule was inserted into the boy's arms but he was found to be proof against inoculation." Had Jenner lived in the nineteenth century his services to humanity would perhaps have earned him rewards and titles. But it could scarcely be said that his discovery was not appreciated. The only danger to his reputation lies in the fact that this generation does not really know what small-pox meant a century ago and hence parents, moved by their infants' tears, were easily persuaded that "they did not hold with" vaccination and that it engendered all sorts of diseases in after life, as though skin eruptions and delicate health were unknown before the days of Jenner. Nothing had been added to Jenner's great discovery and nothing had been found to detract from it. The work Jenner did was essentially work of observation such as any general practitioner might carry out, and if its value were estimated by the saving of life it probably had higher merit than the enunciation of the antiseptic theory or the discovery of anæsthesia. What as to the future? What work was there for the general practitioner to do in the twentieth century to advance the science of medicine? The achievements of the past must be the augury for the future. The work that it was possible for him to do was boundless; it may not like Jenner's mean the saving of countless lives, but it will add to our common stock of knowledge. Could we suppose, for instance, that we had yet perfected the

methods of physical examination of the chest? Could we flatter ourselves that we were approaching the solution of the difficult problems of brain physiology and pathology? Could we assert that our methods of treatment of phthisis were strikingly successful? It would probably be, as of yore, in the class of chronic or of hereditary diseases, or of those ailments which do not require hospital treatment, that the general practitioner would find his richest harvest. One reason why the general practitioner is not doing so much to advance medicine in the present day, the address went on to say, was to be found in the voluminous literature—book and periodical, monograph and annual digest—with which he is supplied like so much peptonised mental food. "It prevents his thinking out problems for himself. He becomes too reverent for authorities and can scarcely believe the evidence of his senses if it conflict with what the books say. The authorities are not infallible and medical knowledge is transitional; the theory hazarded yesterday is accepted as truth to-day and may be disproved to-morrow. Let us question all authority—I do not say disregard it—as far as we are able and doubt all the more the statement that is most dogmatic. Then shall we, the general practitioners, having shaken off the trammels of tradition and authority, be more likely to do our share in the advancement of medicine as Jenner did his one hundred years ago."

Mr. Hayward (Adelaide) was subsequently elected chairman in this Section in the unavoidable absence of Dr. Lendon.

SURGERY.

PRESIDENT'S ADDRESS.

There was a general muster of members in the chemistry lecture room, the President, Dr. BATCHELOR, being in the chair, when

Mr. O'HARA, F.R.C.S.I., senior honorary surgeon of the Alfred Hospital, Melbourne, read his presidential address. He expressed regret that it should have been found necessary to divide medicine and surgery into separate sections. "The two sciences are so closely allied that I feel each section must be losing much valuable teaching in many subjects of common interest. There are in these days of over-specialism certain specialities which can stand alone, as, for example, that of the oculist; but the general surgeon must be a physician, and I hold that to gain eminence as a surgeon one must possess in a high degree the diagnostic powers which are so generally associated with the physician. Any address on contemporary surgery would be incomplete without reference to the loss sustained through the death of Pasteur. He undoubtedly first established the germ theory of putrefaction, and Sir Joseph Lister put it into practical use and introduced to the world the antiseptic treatment of wounds. Having had a large experience in operating under various atmospheric conditions, I have come to the conclusion that where sepsis occurs in a wound it has in most cases been introduced by the operator's hand or by the materials employed during the operation. The most prominent feature in the treatment of disease of late years has been the introduction of sero-therapy, and the most successful results up to date have been achieved with diphtheria. In 1890 Behring of Berlin published his discovery that the serum of immunised animals had a specific action on the diphtheria bacillus. To obtain a sufficient supply of the serum different animals were experimented on, and it was finally decided that the horse was most suitable. It was found to resist without suffering immense doses of the diphtheria poison, and a large supply of the serum could be obtained by simply tapping the jugular vein, a painless proceeding in the case of the horse. The published results of such authorities as Ehrlich, Kossel, Wassermann, Roux, Washbourn, Goodall, and Card in Europe are sufficiently satisfactory to induce us to use the serum in every case. It may not be a specific in all cases, but it has given the most remarkable results in the most hopeless cases and reduced the mortality to less than one-half of that recorded before its introduction. So absolutely hopeless is a case of inoperable cancer that any remedy suggested will be gladly welcomed and will not lack the benefits of a fair trial. That a malignant tumour has disappeared after an attack of erysipelas is an established fact. In my own practice I have had such an experience. The patient, aged fifty years, had a well-marked scirrhus of the right breast, with involvement of the axillary glands. I removed the breast and cleared out the axilla. In two years' time the patient consulted me for a small recurrence in the axillary scar, the greater portion of which I was able to remove. Some of the deeper parts were so intimately mixed up with the artery and vein that I had to leave them. Two days after operation she developed an attack of acute cellulitis, which extended down the arm to the hand. It was necessary to make free incisions into the arm and back of the hand and convalescence was slow. However, it is now six years since the last operation and she is in perfect health with no sign of recurrence. Fehleisen has had a similar experience with a case inoculated with pure cultures of the streptococcus erysipelatis. Bruns and Coley have seen improvements follow an attack of erysipelas and state that the results were more satisfactory in sarcoma than carcinoma. Coley also stated that the factitious erysipelas has not been attended with such good results as the accidental. In treating a case of inoperable recurrent carcinoma four years ago I was astonished to find that a strong solution of ichthyol seemed to arrest the growth. The patient's health improved, and the pain, which was constant and severe, gradually diminished. I determined to push the ichthyol and injected one drachm of a 10 per cent. solution into the margin of the growth daily. The improvement was most marked and when she left my care to return to England she had increased in weight, felt well, and the ulcerated surface had healed considerably at its edges and was only one-third the size it had been two months previously and all disagreeable odour had completely disappeared. I was not able to trace the patient subsequently and cannot, therefore, say what the ultimate result was. I have now under my care a woman whose breast I removed three and a half years ago for a scirrhus that had arrived at the stage of surface ulceration. The axilla appeared to be free at the time, and, her strength failing, I did not remove the glands, as is my custom. A year afterwards the glands became affected and there was marked œdema of the arm. I then cleared out the axilla and prescribed ichthyol internally. She gained flesh and improved rapidly in her general health. A small recurrence took place in the scar subsequently, which was removed, and in spite of all this operative interference she is now in better health than she was four years ago—now there is no sign of disease and she is still taking an ichthyol pill three times daily. I could quote many other cases of inoperable carcinoma where decided improvement took place after the administration of ichthyol, but I cannot claim to have absolutely cured one case, and I only bring it before you as a useful adjunct in the treatment of inoperable cancer. In sarcoma the results have been negative. If the parasitic theory of cancer expounded by Professor Foa at the Medical Congress in Rome proves to be correct we are then within reasonable distance of finding some remedy for it." After alluding to intestinal surgery Dr. O'Hara continued: "I take this opportunity to allude to the strictures passed by Sir W. Priestley on the tendency to over-operate in gynæcology. There is no doubt that along with the great improvements in the methods of operating in this specialty there has been a large increase in the number of operations performed. At the same time I think that, as the majority of gynæcologists are honourable men, outbursts of this kind can serve no useful purpose and only tend to bring unmerited opprobrium on the profession at large—a result which, I am sure, no one would regret more than Sir W. Priestley himself."

In this Section Mr. H. A. de Lautour led off with a paper on a Simple Apparatus for the Treatment of Dislocation of the Acromial End of the Clavicle.

In the Sub-section of Surgery devoted to diseases of the eye, ear, and throat Dr. JACKSON (of Melbourne) presided. A discussion took place on the Test for Vision in Sailors and Railway Men. A committee was appointed to draw up a report.

ANATOMY.

PRESIDENT'S ADDRESS.

Dr. WATSON, Professor of Anatomy in the University of Adelaide, delivered the following presidential address:—

"Allow me in the first place to return you my very cordial thanks for electing me president of this very important section. Any honour conferred by one's professional brethren I, in common with gentlemen occupying similar positions, appreciate very highly. It is not my intention at this late hour to occupy your time longer than is absolutely necessary. At this time of the year

the mind of the hard-worked professional man naturally turns to thoughts of rest and relaxation. I may add that the gathering together of so many professional brethren from all parts of Australasia in this hospitable and scientific focus of the most interesting country on the face of the globe must, apart from its scientific aims, tend to promote that social intercourse and brotherly love which should exist amongst the members of a learned profession such as ours. Our section, although low down on the list, includes those subjects upon which the basis of all scientific medicine must naturally rest. The whole fabric of clinical skill stands on a foundation of anatomy, physiology and pathology and pharmacology requiring for their comprehension a prior knowledge of the subsidiary sciences of physics, chemistry, and biology. The most profound knowledge of the above subjects as pure sciences does not by itself qualify a man for the conscientious practice of his profession. The teacher who only deals with anatomy as a pure science often fails to attach due value to those points which are important in the practice of medicine and surgery. Such a teacher attaches a high value to pure sciences as a means of cultivating the power of observation and stimulating and exercising the reflecting and reasoning faculties. We have heard the same thing said of dead languages, &c., so prone to create hopeless, helpless exasperation in otherwise intellectual individuals not possessing a congenital bias towards their study. It goes without saying that, without ample practical experience, pure scientists cannot be satisfactory healers of the sick. As well might one expect a man to erect fortifications and build bridges who, although he had gone through a course of mathematics and made himself familiar with trigonometry and the calculus, had not practised in the workshops. It cannot be denied that our profession has undertaken the charge and patronage of a body of knowledge only part of which has an application in practice. We do not study anatomy and physiology merely for the sake of pathology, or pathology merely for the sake of cure. For example, physiology of the brain has been studied with a large amount of success in order to explain the ordinary operations of our mind. In fact, it might be said that psychology and the studies depending upon it are at present waiting on physiological investigation; and physiology is a pure science apart entirely from its application in medicine. And the same is true in pathology, which is an indispensable handmaid to physiology. If we were to require our students to study only so much physiology and pathology as are required for the recognition of the diseases they will be called on to treat what would become of the studies of physiology and pathology themselves? The main thing in purely professional education is that the practitioner shall have a scientific interest in his work. This serves a double purpose, because, in addition to being the best guarantee for conscientious treatment, the interest in one's work becomes permanent because it is a scientific interest. This is too often overlooked. There is nothing we want so much as to have an abiding interest in our ordinary work, and it is only a scientific interest which can prevent it from becoming monotonous and stale. Everyone ought to know that the good medical man has not only to possess the requisite knowledge but to have an effective interest in his cases; and what interest can be so good for his patient as a scientific interest? The accompanying sympathetic interest is not acquired; it is cognate and instinctive rather than taught, and I hope we all have it without any training. What the medical man wants to know are the cause and the course of the disease. What does that mean but as intimate a knowledge as we can have of the normal and abnormal growth of tissues? A mere recognition of symptoms and a book of prescriptions added to a pleasant manner may make a student a financially successful practitioner, because unfortunately the general public cannot understand what more is required. But from an educational point of view a medical man who confines himself to that is simply a legalised quack. What he ought to know is cause, and effect, not signs and symptoms alone. The signs and symptoms are effects, and he ought to know their cause: only then is his occupation a profession, and not a mere money-making investment of his life; only then does the patient have the best that we can do for him, both in point of knowledge and of interest in his case. At present the medical profession in every civilised country has undertaken the patronage of anatomy and physiology, and their patronage consists in requiring our students to study them. All professions which can claim to be learned professions are patrons of a learning which is not merely useful for money-getting, but the value of which is as knowledge—mere knowledge; and what knowledge is of greater value than the knowledge of ourselves?"

[Our correspondent expresses his indebtedness to the *Otago Daily Times* for the reports of the presidential addresses in the various sections.]

(To be continued.)

Medical News.

UNIVERSITY OF EDINBURGH.—The following is the official list of candidates who have just completed the first professional examination for the degrees of M.B. and C.M.:—

Violet G. S. Adams, T. H. W. Alexander, Eliza M. Anderson, A. J. Baird, S. A. Ballantyne, J. W. Barrack, J. A. Black, G. H. Boyden, L. P. Brassey, George Brogden, Launcelot Bruce, Adam Brydon, Malcolm Campbell, Riley Carr, W. J. Collinson, John Craig, T. Ashton Davies, Horace B. Dodds, J. P. Douglas, D. R. Evans, Edward Ewart (with distinction), A. Binny Flett, A. S. Frank, William Girdwood, J. L. Green, Robert Hamilton, Herbert Harris, A. E. Henton, Katie W. Hogg, Edith J. Hudson, John Jamison, Joseph Johnstone, Langworthy Laurie, R. G. Leach, E. A. Loch, Gerard Lowther, C. R. M'Conagy, Bessie G. Macdonald, John M. Macdonald, A. F. Mackay, T. A. Mackenzie, H. J. M'Lean, A. G. M'Leod, R. A. M. Macleod, James Macpherson, L. W. Macpherson, A. A. Martin, Harry Mason, E. T. Melhuish, Mary J. Menzies, M. C. Morgan, Janet A. S. Mouat, A. C. Neethling, Horace C. Nixon, C. F. Noble, L. D. Parsons, Winifred J. Pierce, S. C. Pritchard, William Purves, F. G. Ralston, T. E. Richards, Catherine M. Richardson, David Robertson, G. H. W. Robertson, R. A. Ross (with distinction), Richard Rutherford, H. D. Shepherd, F. D. Simpson, C. E. Smith, C. E. Southon, Bernard Stracey, Esther M. Stuart, F. T. Thompson, G. R. Turner, Charles Vartan, D. L. Wall, William Wallace, C. Heron Watson, P. D. Whiriskey, W. G. Williams, M. Ruth Wilson, T. J. G. Wilson, and Frank Young.

FOREIGN UNIVERSITY INTELLIGENCE.—*Berlin:* Dr. O. Hildebrand has been promoted to an Extraordinary Professorship of Surgery. Dr. Oestreich has been recognised as *privat-docent* in General and Anatomical Pathology.—*Griefswald:* Dr. Otto Schirmer has been promoted to the Chair of Ophthalmology in succession to the late Dr. Rud. Schirmer.—*Cracow:* Dr. Klecki has been recognised as *privat-docent* in General and Experimental Pathology.—*Halle:* Dr. R. Wollenberg has been promoted to an Extraordinary Professorship of Psychiatrics.

DIPHTHERIA MORTALITY IN LONDON IN 1895.—Diphtheria showed a smaller fatal prevalence in London last year than in 1894, though still in excess of the average for the decennial period 1885-94. There were 2316 deaths from this cause in the metropolis in 1895, but there were 3265 in 1893, and 2670 in 1894. Thus the decrease, substantial as it was in 1895 over the preceding year, compared still more favourably with the total of two years back. The rate of mortality from diphtheria in 1895, variously stated in the annual summary of the Registrar-General as 0·52 and 0·53 per 1000 persons living, contrasts with the decennial average rate of 0·38. The mortality in 1895 was by no means uniform over the several groups of sanitary districts, as we find that, taking 0·52 as the rate for London as a whole, the groups run thus:—Northern, 0·40; central, 0·42; western, 0·48; southern, 0·51; and eastern, 0·81. In London in 1895 the increase over the decennial average has been at the rate of 37 per cent., but in the northern group it has only been 8, and in the central group 17, the other groups showing—in the western, 33; in the southern, 42; and in the eastern group as much as 69 per cent. increase. Or reading the data in another fashion, we find that if London be regarded, in so far as the rate of mortality in 1895 is concerned, as represented by 100 then the various groups had mortality rates severally of 77 in the northern, 81 in the central, 92 in the western, 98 in the southern, and 156 in the eastern group. Both as regards increase over the decennial average and as regards relation to the total mortality ratio in 1895 the southern and eastern (especially the latter) show to great disadvantage. It is in reality the excessive rate in the eastern group which raises the London rate to its present position. The notified cases in the year 1895 numbered for the whole metropolis 11,426, and on this total the 2316 deaths work out to a case mortality of 20·3, but this total of notifications includes some duplicate notifications of single cases, though these are trivial in number as

compared with the aggregate of attacks. The hospital cases in London last year were 3688, or just 3 fewer than in the preceding year; but the number of fatal cases among them was much less—namely, 824, or 22·3 per cent. of the admissions, as compared with 1041 deaths, or 28·2 per cent. of the admissions in 1894. Whether the decline be put down to the use of serum or be explained in some other way it is a pleasing feature in the hospital records. In actual figures the decrease in deaths from diphtheria in London in 1895, as compared with the previous year, was 611; whilst if croup be added to the diphtheria deaths the total of fatalities reached 2460—a number only 376 fewer than in 1894, and 299 in excess of the decennial average.

We are informed that the Peninsular and Oriental Company have recently entered into contracts for four mail steamers of the highest class, similar in type to, but larger than, the *Caledonia*, *Australia*, and *Himalaya*, now running in the Eastern services, which will accommodate about 500 first and second-class saloon passengers. These vessels are each 500 feet in length, with proportionate beam and power, measuring about 8000 tons register, with machinery to indicate 11,000 horse-power. They are being built by Messrs. Harland and Wolff and Messrs. Caird and Co., and the first two ships, which have been named the *India* (which was launched on Wednesday last) and the *China* (to be launched on June 13th), will be ready for service during the coming autumn.

BRISTOL HOSPITAL FOR CHILDREN AND WOMEN.—The thirtieth annual meeting of the subscribers of the Bristol Hospital for Children and Women was held on March 21st, the Mayor presiding. From the report it appeared that during 1895 there had been 855 children and 31 women admitted as in-patients, and 1237 women and 3096 children were treated as out-patients. The committee regretted that in consequence of ill-health Dr. Roué had been obliged to resign his appointment as one of the acting staff. The ordinary revenue of the hospital has not been sufficient to meet the expenditure by £150, so that, including the small balance to the debit with which the year commenced, the treasurer's account shows an adverse balance of £189 16*s.* 8*d.*

THE DIFFUSION OF SMALL-POX.—In Gloucester the intensity of the disease has been maintained, the record total of 210 cases in the week ending April 4th giving way to the total in the week ending last Saturday. But the daily notifications reached their maximum on Friday of last week, when there were 48 attacks brought to the knowledge of the Town Council. Next day the cases fell to 26, on the Sunday they fell further to 14, and on Monday of the current week only 13 fresh attacks were chronicled. It is to be hoped that this favourable decline may be continued, while the immense number of recent vaccinations will exert a beneficial effect on the progress of the epidemic. The rush to the public vaccination stations has not abated, the vaccination of some half of the citizens has been effected. The remaining half are not all unprotected, as a large proportion of the adult population have the benefit of infantile vaccination. In the fortnight ended on Saturday last there were no fewer than 4414 persons vaccinated by the public vaccinators, and the guardians have made a complete change of front, and have by their latest procedures hit the anti-vaccination party very hard indeed. There were 5 cases of small-pox in the Cheltenham Hospital at the close of the first week of April. At Bristol 11 cases of small-pox came to the knowledge of the health officer in the two weeks ended April 9th, 6 being connected with a previous case at Barton Regis. Two were so slight as to be difficult of diagnosis, and it took thirteen hours' search to find one patient in the city, this instance being illustrative of the dangers attending mild and unrecognised attacks. At Exeter ten days ago there were 13 cases in hospital, coming from St. Thomas, Heavitree, and elsewhere; and a resolution of the guardians to enforce the Vaccination Acts, which have for so many years been a dead letter there, was recently carried by a majority of 12 votes to 4. At Coventry the determination of the guardians to enforce vaccination has led the anti-vaccinationists to a resolve to stay if possible the carrying out of the guardians' intention. Cases of small-pox are reported at many places in the Forest of Dean—namely, 2 at Alvington, 4 at Steam Mills, 2 at Bollow, 2 at Whitcroft in Weston, and 1 each at Dinny and Cinderford Mecnd. The Westbury guardians, presumably acting as rural district council, have appointed an additional inspector and have contracted for an iron hospital. Three cases of small-pox have been brought into Swansea docks by the sailing vessel *Harland*, and all were conveyed to hospital. At Heywood the small-pox patients are progressing, but it is estimated that there are 1000 unvaccinated children in the town. At West Hartlepool one of the crew of the *Harland* has sickened of small-pox, as has also a young lady recently from Gloucester. There are many manifestations of the spread of small-pox by tramps in the vicinity of Gloucester and gradual widening of this influence is to be expected.

SOCIETY FOR RELIEF OF WIDOWS AND ORPHANS OF MEDICAL MEN.—A quarterly court of the directors of this society was held on April 8th at 11, Chandos-street, W., Mr. Christopher Heath, vice-president, being in the chair. The deaths of two widows were reported, one having been in receipt of grants since May, 1860, and having received £1798, her husband subscribing thirty-six guineas. Fresh applications for grants were read from four widows and four orphans, and a sum of £80 10*s.* was given among them. Applications for further assistance were made from forty-eight widows and seven orphans, and a sum of £1141 10*s.* was recommended to be distributed at the July court. Four members were elected and the deaths of four announced. A further sum of £215 had been received from the executors of Miss Carpue, making in all £3215 paid. The following gentlemen were nominated for election as directors at the annual general meeting, to fill the vacancies caused by the death of Mr. Rouse and the retirement of the six seniors—viz., Mr. W. H. Bennett, Dr. Wilks, Dr. Frederick Roberts, Dr. Sylvester, Mr. Malcolm Morris, Mr. Fountaine, and Mr. Butlin. The annual general meeting was fixed to be held on May 20th, at 5 P.M.

THE LOCAL GOVERNMENT BOARD AND WORKHOUSE NURSES.—On Wednesday last Mr. Chaplin received a deputation at the House of Commons from the Workhouse Infirmary Nursing Association to discuss the question of the inadequate number of nurses employed in workhouse infirmaries, and necessary alterations in their status. The deputation was introduced by Lord Montagu of Beaulieu, who stated that the association was founded in 1879 in order to supply boards of guardians with competent and duly-trained nurses. Over 700 nurses had been appointed, and of these 135 were now at work. The present state of nursing in the majority of workhouse infirmaries was capable of improvement; it was desirable to promote the employment of paid and efficiently trained nurses in all such places; and the appointment of a hospital-trained lady superintendent to be at the head of each staff of trained nurses was essential to the efficiency of the system. The President of the Local Government Board said he would carefully consider the complaint that in so many infirmaries the nursing staff was still insufficient. The question of want of accommodation was a difficult one. As to pauper assistants, the Local Government Board had again and again discouraged their employment.

PRESENTATIONS TO MEDICAL MEN.—Mr. J. Lacy Firth was presented, at the Bristol General Hospital on the 19th ult., by the resident medical officers, students, and nursing staff, with a handsome writing table as a mark of their esteem upon his retirement from the post of resident medical officer, he having been appointed assistant surgeon to that institution.—Dr. J. S. Riddell, lecturer to the Police and Railway Ambulance Class, Aberdeen, in connexion with the St. John Ambulance Association, has been presented by the members of the class with a handsomely mounted microscope.—Mr. James Cantlie, who has been in practice for the past nine years at Hong Kong, has left on account of ill-health to return to England. Prior to his departure from that city he was presented with several addresses from public bodies, signed by representative members of the community, and was also the recipient of a handsome tea and coffee service.—On the 8th inst., Dr. W. B. Mackay of Berwick-on-Tweed, on the occasion of presenting the certificates awarded to the ambulance classes under the auspices of the St. John Ambulance Association to the members of the North-Eastern Railway servants, was the recipient of three volumes of medical works.—Dr. J. Johnston of Bolton, has been presented by the members of the ambulance class connected with the Mawdsley-street Evening Continuation

School with a handsome ebony silver-mounted walking-stick and a pocket-book.—Dr. J. Hilton Thompson of Bolton, at a meeting in the St. Luke's School, on Saturday last, to present the certificates and medallions to the successful members of the ambulance class, was the recipient of a handsome breakfast service and a set of jugs.

FOOTBALL CASUALTY.—On the 14th inst., at Nelson, in a Lancashire League match between the Nelson and Southport Central teams, the Nelson's outside left forward fractured his right leg below the knee.

A GENEROUS GIFT.—Some time ago the directors of the Paisley Infirmary issued an appeal for subscriptions. Mr. Peter Coats, of the Ferguslie Thread Works, has promised a donation of £10,000. Mr. Coats previously subscribed £5000, and is stated to be also building a nurses' home at a cost of about £10,000.

FRENCH HOSPITAL AND DISPENSARY.—The twenty-eighth anniversary banquet on behalf of the funds of this institution is announced to take place at the Whitehall Rooms of the Hôtel Métropole on Saturday, April 25th, his Excellency the French Ambassador (Baron de Courcel) in the chair, supported by the Lord Mayor of London. Tickets (£1 1s.) may be obtained from the hon. secretary, French Hospital, Shaftesbury-avenue, W.C.

Parliamentary Intelligence.

CURRENT NOTES.

Venereal Disease in the Army.

MR. JAMES STUART has given notice that he will endeavour to find an opportunity to call attention to the state of the army in India and elsewhere as regards venereal disease and to move a resolution on the subject. In the present state of Parliamentary business there is little prospect of Mr. Stuart finding the opportunity he desires.

Shops (Early Closing) Bill.

Several Members not satisfied with the consideration given to this Bill by the Grand Committee on Trade have notified that it is their intention to move that the measure be now dealt with in Committee of the whole House.

Nursing in Workhouse Infirmaries.

On the afternoon of Wednesday, April 15th, in his room at the House of Commons, Mr. Chaplin, President of the Local Government Board, received a deputation from the Workhouse Infirmary Nursing Association. The object of the deputation was to ask the right hon. gentleman to take steps to secure the appointment of only trained nurses to workhouse infirmaries, to define the position of the trained nurse in relation to the untrained matron and the master of the workhouse, and to abolish pauper help in nursing duties. Lord Montagu, in introducing the deputation, explained to Mr. Chaplin that the Association was founded in 1879 in order to supply boards of guardians with competent and thoroughly trained nurses; that during the sixteen years over 900 applications have been received from boards of guardians, and over 900 nurses have been appointed; 135 of these being now at work. Mr. Frederick Feeney, a guardian of the poor of Cheltenham, addressed Mr. Chaplin with special reference to the unsatisfactory state of the nursing arrangements in rural districts. Miss L. Twining dwelt on the importance of separating infirmaries from workhouses, and Dr. Dolan of St. Luke's Hospital, Halifax, expressed the views of the association with regard to the position of the trained nurse.—Mr. Chaplin in his reply spoke in complimentary terms of the work of the association, and recommended it to the support of the public. He assured the deputation that the Local Government Board were fully alive to the defects in the present system of nursing in these institutions. They had already done something to remedy them although he confessed that much remains to be done, and he promised to give most careful attention to the views put forward by the deputation.

The London Water Question.

At this sitting there was a short debate upon the supply of water in the East-end of London. It arose in connexion with a Bill whose main purpose was to increase the statutory pressure required of the East London Water Company; but in view of certain circumstances connected with the promotion of the measure, the second reading was not pressed, and in the end the Bill was withdrawn.

Grants to University Colleges.

Mr. Balfour, replying to a question by Mr. Carvell Williams as to whether the Parliamentary grant to King's College would not only be restored but considerably increased, said that no increase was proposed in the Estimates this session. The Chancellor of the Exchequer, in accordance with an undertaking given by him to a deputation which waited upon him, had appointed three gentlemen—Mr. T. H. Warren, President of Magdalen College, Oxford; Professor D. G. Liveing, Fellow of St. John's College, Cambridge; and Mr. Chalmers of the Treasury—to visit the Colleges sharing in the grant made to Universities and Colleges in Great Britain and to investigate the character and quality of the University work done and to inquire generally into the position which such College occupied both financially and in other respects. When their report was received, which the Chancellor of the Exchequer expected would be some time in the autumn, he would be in a position to judge whether a case had been made out for recommending Parliament to increase the sum to each of the Colleges sharing in the grant.

HOUSE OF COMMONS.

THURSDAY, APRIL 9TH.

University of London.

Sir Albert Rollit questioned the Government again with regard to their intentions in the matter of the report of the Gresham Commission, but Sir John Gorst could give no further information than to say that the subject is still under consideration.

FRIDAY, APRIL 10TH.

The Ventilation of the House.

When the House was in Committee of Supply and considering a vote of £23,900 for work on the buildings of the Houses of Parliament Dr. Farquharson raised the question of the ventilation of the House of Commons, and asked the Government for information as to what had been done. Mr. Akers-Douglas, First Commissioner of Works, in his reply said that while better ventilation might be required in other portions of the building, so far as the legislative chamber was concerned it was certainly one of the best-ventilated rooms that could be found anywhere. He could bear witness to the very great care which was taken by the officials in charge of the ventilating department. He had taken a personal interest in the matter since his appointment as First Commissioner, and had made a point of constantly visiting the ventilating rooms, and hon. Members who had accompanied him had been greatly struck with the enormous staff and the appliances which were provided in order to secure the comfort of Members of the House. He had, in accordance with a promise made when the Estimates were under discussion last year, gone carefully into the subject, and he thought he had met the different complaints and remedied the various grievances which were then urged. Ventilating shafts had been placed in the Victoria Tower and improvements had been carried out in the kitchen and smoking rooms and other parts of the building.

Portsmouth Quarantine Stations.

Two sessions ago exception was taken to the money annually spent on the maintenance of the two quarantine stations near Portsmouth for the treatment of plague and yellow fever, and this session the Government brought in a Bill to abolish the charge and hand over the stations to the port sanitary authorities for the purposes of the latter. The Bill was brought up at this sitting of the House, and after being explained by Mr. T. W. Russell was read a second time.

MONDAY, APRIL 13TH.

Inquests on Railway Accidents.

Mr. Channing asked the President of the Board of Trade whether he could state what was the number of inquests held on railway servants killed in the discharge of their duties during the year 1895; at how many of such inquests the Board of Trade was represented by an inspecting officer, a sub-inspector, or other representative; and in how many instances the coroner applied for an official of the Board of Trade to attend as an assessor, in pursuance of Section 8 of the Regulation of Railways Act of 1871.—Mr. Ritchie replied: Two hundred and seventy-six coroners' returns were received by the Board of Trade in 1895. In no case did the coroner apply for an assessor in pursuance of the Act, but in three cases coroners asked for technical assistance, and in two cases such assistance was given, in one by an inspecting officer and in the other by a sub-inspector. In the third case the coroner asked for scientific evidence, and this the Board of Trade were unable to give.

Lead Poisoning.

Mr. John Wilson (Falkirk) asked the Secretary of State for the Home Department if he would order an inquiry into the conditions of the enamel industry with a view to dispense with the use of lead, so that the large percentage of deaths through lead poisoning might be averted.—Sir Matthew White Ridley said in reply: The hon. Member will no doubt remember that the various lead industries formed the subject of an exhaustive inquiry by a departmental committee three years ago, as a result of which stringent special rules have been established for factories where lead is used in plate enamelling. Considerable difficulty, however, is experienced in getting the workpeople to obey the rules, nor am I satisfied that they might not be amended. I propose, therefore, to have a further inquiry made.

Ill-treatment of Children.

Mr. MacAleese asked the Secretary of State for the Home Department whether he had seen the report of the National Society for the Prevention of Cruelty to Children, wherein it was stated that there were investigated last month 1965 complaints of neglect, starvation, ill-treatment, and other wrongs upon children, that 1837 of those complaints were found to be true, and affected the welfare of a large number of children of various ages, and that eighteen of the children so affected died; and would the Government consider the propriety of making more stringent the laws in existence for the protection of helpless children?—Sir Matthew White Ridley replied that his attention had not been previously called to the report referred to. The Prevention of Cruelty to Children Act of 1894, which consolidated and extended previous legislation on the subject, was passed after much discussion in Parliament, and he had not as yet seen any reason to suppose that it was ineffective for its purpose. No representations to

the effect that the law required strengthening had been made to the Home Office by magistrates or others concerned in its administration, but should any such representations be received they would, of course, be carefully considered by him.

TUESDAY, APRIL 14TH.

The Small-pox Epidemic at Gloucester.

Mr. Ascroft asked the Secretary to the Treasury, as representing the Postmaster-General, if any means were being taken by the postal authorities at Gloucester to disinfect the letters and papers deposited in the pillar boxes which were situated in the infected areas; and whether he would cause inquiries to be made as to the same and give such instructions as he may be advised were necessary to prevent the spreading of the small-pox epidemic to other parts of the kingdom?—Mr. Hanbury replied: Instructions have been given for the use of disinfectants at the Gloucester Post-office with the view of reducing as far as practicable the risks of infection during the prevailing epidemic.

BOOKS, ETC., RECEIVED.

ADLARD AND SON, Bartholomew Close, London, E.C.

King's College Hospital Reports; being the Annual Report of King's College Hospital, and the Medical Department of King's College. Vol II. (Oct. 1st, 1894—Sept. 30th, 1895). 1896.

BAILLIÈRE, TINDALL, AND COX, King William-street, Strand, W.C.

A Guide to the Practical Examination of Urine. By James Tyson, M.D. Ninth Edition. Illustrated. 1896. Price 7s. 6d.

CONSTABLE, A., AND CO., Westminster.

The Volunteers and the National Defence. By Spenser Wilkinson. 1896.

CHURCHILL, J. & A., 7, Great Marlborough-street, London.

St. Thomas's Hospital Reports. New Series. Edited by Dr. T. D. Acland and Mr. Bernard Pitts. Vol. XXIII. 1896.

The Pharmacopœia of the Evelina Hospital for Sick Children, Southwark. Second Edition. 1896. Price 1s. 6d.

DEIGHTON, BELL AND CO., Cambridge.

Cholera in Indian Cantonments, and How to Deal with it. By E. H. Hankin, M.A. 1895. Price 2s. 6d.

DORMAN, WM. J., Philadelphia.

Transactions of the American Surgical Association. Vol. 13. Edited by De Forest Willard, Ph.D., M.D. 1895.

Transactions of the American Gynæcological Society. Vol. 20, for the year 1895.

FANNIN AND CO., Dublin.

Transactions of the Royal Academy of Medicine in Ireland. Vol. 13. Edited by Wm. Thomson, M.A., F.R.C.S. 1895.

FERET AND FILS, Bordeaux.

Faculté de Médecine de Bordeaux, Travaux de la Clinique de Dermatologie du Dr. W. Dubreuilh. 1895.

FISCHER, GUSTAV, Jena.

Die Otogene Pyämie. Von Dr. H. Hessler. 1896.

Grundriss einer Klinischen Pathologie des Blutes, für Arzte und Studirende. Von Dr. Rud. R. v. Limbeck. Zweite Auflage. Mit einem Beitrage die Gerinnung des Blutes, von Dr. E. Freund. 1896.

Ueber die Flimmercysten der Zungenwurzel und die drüsigen anhänge des Ductus thyreoglossus. Von Dr. M. B. Schmidt. 1896.

Beiträge zur Gallenblasenchirurgie. Von Dr. Georg B. Schmidt. 1896.

Die Krankheiten des Gehirns und seiner Adnexa im Gefolge von Naseneiterungen. Von Dr. R. Dreyfuss. 1896.

KEGAN PAUL, TRENCH, TRÜBNER, AND CO., Charing-cross-road, London, W.C.

Water Analysis. By J. A. Wanklyn and E. T. Chapman. Tenth edition. 1896. Price 6s.

Domestic Sanitary Drainage and Plumbing. By W. R. Maguire. Second Edition. 1896. Price 12s.

LEA BROTHERS AND CO., Philadelphia.

The Toxic Amblyopias: their Classification, History, Symptoms, Pathology, and Treatment. By G. E. de Schweinitz, A.M., M.D. Illustrated. 1896.

LEWIS, H. K., Gower-street, London, W.C.

Current from the Main: the Medical Employment of Electric Lighting Currents. By W. S. Hedley, M.D. 1896. Price 2s. 6d.

Rough Notes on Remedies. By W. Murray, M.D. Lond. 1896. Price 3s. 6d.

Public Health Laboratory Work. By H. R. Kenwood, M.B., D.P.H. Second edition, illustrated. 1896. Price 10s. 6d.

MACLEHOSE, JAMES, AND SONS, Glasgow.

Memorials of the Faculty of Physicians and Surgeons of Glasgow, 1599-1850. By Alexander Duncan, B.A. Lond. 1896.

MACMILLAN AND CO., Bedford-street, London, W.C.

Atlas of Nerve Cells. By M. Allen Starr, M.D., Ph.D., and others. Illustrated. 1896. Price 42s. net.

NUTT, D., Strand, London.

Ein Mittelenglisches Medizinbuch. Von Fritz Heinrich. 1896.

PENTLAND, YOUNG J., Edinburgh.

Atlas of the Diseases of the Skin. By H. Radcliffe Crocker, M.D., F.R.C.P. Fasciculus 15.

Published by the NEW YORK COUNTY MEDICAL ASSOCIATION, State of New York.

Register of Members, Manual of Information. 1895.

Published by the SMITHSONIAN INSTITUTION, City of Washington.

Smithsonian Contributions to Knowledge, 989. Hodgkins Fund. The Composition of Expired Air and its Effects upon Animal Life. By J. S. Billings and others.

SAUNDERS, W. B., Walnut-street, Philadelphia.

Diets for Infants and Children in Health and Disease. By Louis Starr, M.D. 1896.

SMITH, ELDER, AND CO., Waterloo-place, London, S.W.

The Treatment of Phthisis. By A. Ransome, M.D. Cantab., F.R.S. 1896. Price 7s. 6d.

Saint Bartholomew's Hospital Reports. Edited by S. West, M.D., and W. J. Walsham, F.R.C.S. Vol. 31. 1895.

ST. BRIDES' PRESS, Bride-lane, Fleet-street, London, E.C.

The Sewerage Engineer's Note-book. By Albert Wollheim, Assoc. M. Inst. C.E., reprint. 1896. Price 2s. 6d. net.

THE F. A. DAVIS COMPANY, Philadelphia.

Diagnosis and Treatment of Diseases of the Rectum, Anus, and Contiguous Textures. By S. G. Gant, M.D. With chapters on "Cancer" and "Colotomy." By Herbert W. Allingham, F.R.C.S. Eng. Illustrated. 1895.

THE JOHNS HOPKINS PRESS, Baltimore.

Physiological Papers. By H. Newell Martin. 1895.

WHITTINGHAM, W. B., AND CO., Gracechurch-street, London.

Argon and Newton: A Realisation. By Lieutenant-Colonel W. Sedgwick. 1896.

Fruit and Gardens for the People; by the Hon. Dudley Campbell (Burnett and Russell, Strand, London, W.C., 1896).—Archives de Pharmacodynamie; par E. Gley, Paris, and J. F. Heymans, Gand; Vol. II., Fascicules 3 and 4 (H. Engelcke, Gaud, et O. Doin, Paris, 1896).—The Journal of Mental Science, April, 1896 (J. & A. Churchill, London); price 5s.—The Chalybeate Bath, Haarlem; by C. E. Daniels, M.D., Amsterdam (published by the Company for the Exploitation of Chalybeate Springs at Haarlem).—Archives de Physiologie, No. 2, 1896 (Masson et Cie, Paris).—Atlas der Pathologischen Anatomie; von Dr. O. Bollinger; II. Heft, 1896 (J. F. Lehmann, München).—Diphtheritis und Cellulartherapie; von Dr. F. Neumayer (J. F. Lehmann, München, 1896).—Der geborene Verbrecher: eine Kritische; von Dr. E. Bleuler (J. F. Lehmann, München, 1896).—Die Asepsis in der Landpraxis; von Dr. H. Doerfler (J. F. Lehmann, München, 1893).—Ueber die Untersuchung, Beurteilung und Behandlung von Unfallkranken; von Dr. A. Strümpell (J. F. Lehmann, München, 1896).—Von Sudthausen's Guide for the Use of Doctors and Apothecaries: English-German (E. Besold (A. Georgi), Leipzig).—Von Sudthausen's Sprachführer für die ärztliche und pharmaceutische Praxis: Deutsch-Englisch (E. Besold, Leipzig).—Transactions of the American Pediatric Society; Seventh Session; Vol VII.; reprint from the Archives of Pediatrics; 1895.—Queen's College, Galway: Calendar for 1895-96 (Ponsonby and Weldrick, Dublin, 1896).—A Contribution to South African Materia Medica, chiefly from Plants in Use among the Natives; by Andrew Smith of St. Cyrus, M.A.; Third Edition (J. C. Juta and Co., Cape Town, Port Elizabeth and Johannesburg); price 3s., postage 4d.—Ueber die Behandlung von Nervenkranken und die Errichtung von Nervenheilstätten; von Dr. P. J. Mobius, Leipzig (Williams and Norgate, Henrietta-street, Covent-garden, London, W.C.)—The British Gynæcological Journal; Part 44, February, 1896 (John Bale and Sons, Great Titchfield-street, Oxford-street, London, W.); price 3s. 6d.—Magazines, &c., for April: Strand Magazine, Strand Musical Magazine, Boys' Own Paper, Girls' Own Paper; Leisure Hour, Sunday at Home, The Minster, Ludgate Magazine, Chapman's Magazine, Pall Mall Magazine, Westminster Review, Contemporary Review, Friendly Greetings, The Gymnast and Athletic Review.

Appointments.

Successful applicants for Vacancies, Secretaries of Public Institutions, and others possessing information suitable for this column, are invited to forward it to THE LANCET Office, directed to the Sub-Editor, not later than 9 o'clock on the Thursday morning of each week for publication in the next number.

ANDREWS, H. A., L.R.C.P. Lond., M.R.C.S., has been appointed House Surgeon to the Grimsby and District Hospital.

BENNETT, C. H. W., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer of Health by the Congleton Rural District Council.

BERLYN, J. A., L.R.C.P. Lond., M.R.C.S., has been appointed Resident Medical Officer to the Birmingham and Midland Free Hospital for Sick Children.

BIRD, J. W., M.R.C.S. Eng., L.R.C.P. Lond., has been appointed Junior Assistant House Surgeon to Hull Royal Infirmary.

BURDWOOD, J. W., L.F.P.S., L.M. Glasg., has been reappointed Medical Officer by the Bourne Rural District Council.

CALDICOTT, C. H., L.R.C.P. Lond., M.R.C.S., has been appointed Resident Surgical Officer to the Birmingham and Midland Free Hospital for Sick Children.

CLAYTON, J. H., M.B. Lond., L.R.C.P., M.R.C.S., has been appointed Extra Acting Surgeon to the Birmingham and Midland Free Hospital for Sick Children.

DE BUTTS, Stanley B., M.D. Brux., M.R.C.S., has been appointed anæsthetist to the Grosvenor Hospital for Women and Children, Westminster.

FRASER, W. D., M.B., C.M. Edin., has been reappointed Medical Officer of Health by the Colwyn Bay Urban District Council.

GOODING, M. R., L.R.C.P. Lond., M.R.C.S., has been reappointed Medical Officer of Health by the Bideford Town Council.

HANNAH, WILLIAM TWEED, M.B., C.M. Glasg., D.P.H. Camb., has been appointed Medical Officer and Public Vaccinator for the Buxton District, Chapel-en-le-Frith Union.

HASWELL, J. F., M.B., C.M. Edin., M.R.C.S., has been reappointed Medical Officer by the Penrith Rural District Council.

HEALEY, J., M.B., Ch.B. Vict., has been appointed Medical Officer of Health, Moseley, Lancs.

HOFFMEISTER, W., M.D. Heidelb., L.R.C.P. Lond., M.R.C.S., has been reappointed Medical Officer of Health, East Cowes.

KENNY, M. E., M.B., B.Ch. Dubl., has been appointed Medical Officer for the Carrick-on-Suir Union Infirmary, vice A. O'Ryan, resigned.

LAMBERT, P., L.R.C.P. Lond., M.R.C.S., has been reappointed Medical Officer for the Third Sanitary District of the Newbury Union.

LITTLE, E. G. GRAHAM, B.A., M.D., M.R.C.P., has been appointed Assistant Curator of the Museum at St. George's Hospital.

MACDONALD, WILLIAM, L.R.C.P., L.R.C.S. Edin., has been appointed Junior House Surgeon to the Royal Albert Edward Infirmary, Wigan.

MAW, H. S., L.S.A. Lond., has been appointed House Surgeon to the Teignmouth Hospital.

MILROY, W. CUNNINGHAM, M.A., M.D. Edin., has been appointed Senior House Surgeon to the Royal Albert Edward Infirmary, Wigan.

MORISON, J., M.D. Edin., M.R.C.S., D.P.H. Camb., has been reappointed Medical Officer of Health by the St. Albans Rural District Council.

POLLOCK, E. S., M.B., B.Ch. Dubl., has been appointed Medical Officer for the Sixth Sanitary District of the South Molton Union.

PRATT, A. A., M.B., C.M. Glasg., has been appointed Honorary Medical Officer to the Grimsby and District Hospital.

REEKS, HENRY, M.R.C.S. Eng., L.R.C.P. Lond., has been appointed Medical Officer to the Steyning Union.

REID, GEORGE A., M.B., C.M. Aberd., has been appointed Junior Assistant Medical Officer to the Cumberland and Westmoreland Co. Asylum at Carlisle.

RIDING, E., M.R.C.S., has been reappointed Medical Officer of Health for Repton.

SAVAGE, GEORGE H., M.D. Lond., has been appointed Physician for Mental Diseases, Guy's Hospital.

SCURFIELD, HAROLD, M.D., C.M. Edin., D.P.H. Camb., has been appointed Medical Officer of Health for Sunderland.

SNOW, L. M., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Second Sanitary District of the Horsham Union, vice Kirsopp, resigned.

STONEY, P. B., L.R.C.P., L.M. Edin., M.R.C.S., has been reappointed Medical Officer of Health by the Millom Urban District Council.

TURNER, C. B., L.R.C.P. Lond., M.R.C.S., has been appointed Honorary Medical Officer to the Grimsby and District Hospital.

WALCOT, THOS., M.D., C.M. Edin., M.R.C.S., has been appointed Medical Officer of Health by the York Town and Camberley Urban District Council.

Vacancies.

For further information regarding each vacancy reference should be made to the advertisement (see Index).

CHELSEA HOSPITAL FOR WOMEN, Fulham-road, S.W.—Two Clinical Assistants, for three months, on payment of £5 5s.

HALIFAX INFIRMARY AND DISPENSARY.—Assistant House Surgeon, unmarried. Salary £50 per annum, with residence, board, and washing.

HOSPITAL FOR SICK CHILDREN, Great Ormond-street, Bloomsbury, W.C.—House Physician, for six months, unmarried. Salary £20, with board and residence in the hospital.

HUDDERSFIELD INFIRMARY.—Junior House Surgeon for one year. Salary £40 per annum, with board, lodging, and washing.

LEICESTER INFIRMARY.—Honorary Ophthalmic Surgeon.

MACCLESFIELD GENERAL INFIRMARY.—Junior House Surgeon. Salary £70 per annum, with board and residence in the institution.

NORTH-WEST LONDON HOSPITAL, Kentish Town-road.—Resident Medical Officer and Assistant Resident Medical Officer. Each appointment for six months. Salary for senior post at the rate of £50 per annum.

OWENS COLLEGE, Manchester.—A Senior and a Junior Demonstrator in Physiology.

OWENS COLLEGE, Manchester.—Junior Demonstrator in Anatomy.

SOUTH DEVON AND EAST CORNWALL HOSPITAL, Plymouth.—Assistant House Surgeon for six months. Board and residence provided, and an honorarium of £10.

SUNDERLAND BOROUGH ASYLUM, Ryhope, Sunderland.—Resident Clinical Clerk, for six months. Board and lodging provided, with a nominal salary.

WESTMINSTER HOSPITAL, Broad Sanctuary, S.W.—Surgical Registrar for twelve months. Salary £40 per annum.

WEST RIDING OF YORKSHIRE.—Medical Officer of Health for the Riding. Salary £400 per annum, with travelling expenses, and a suitable staff and laboratory and office provided. Applications to Mr. T. Edwards, West Riding Solicitor, Wakefield.

WREXHAM INFIRMARY AND DISPENSARY.—House Surgeon. Salary £80 per annum, with furnished rooms, board, gas, coal, and attendance.

Births, Marriages, and Deaths.

BIRTHS.

ATKIN.—On April 10th, at Fern Bank, Sheffield, the wife of Charles Atkin, F.R.C.S. Eng., of a son.

BERNAU.—On April 6th, at Napier, New Zealand, the wife of Henry F. Bernau, M.R.C.S., L.R.C.P., of a son.

BOXALL.—On April 12th, at Rudgwick, Sussex, the wife of Frank Boxall, M.R.C.S., L.R.C.P., of a son.

COOK.—On April 14th, at Stewarton, Aryshire, the wife (née Puckle) of James Cook, M.B., C.M. Glasg., of a son.

EDWARDS.—On April 12th, at Brunswick-square, W.C., the wife of Robert Edwards, M.D., of a son.

FOLKER.—On April 7th, at Havelock-place, Hanley, Staffordshire, the wife of Herbert H. Folker, M.R.C.S., L.R.C.P., of a daughter.

GAGE-BROWN.—On April 9th, at Cadogan-place, the wife of C. H. Gage-Brown, M.D. Edin., of a daughter.

KING.—On April 14th, at Nicholas-street, Chester, the wife of Henry W. King, M.D. Edin., M.R.C.S., of a son.

LIEBSTEIN.—On April 9th, at Cairn Ryan, Preston, Brighton, the wife of David W. Liebstein, M.R.C.S. Eng., L.R.C.P. Lond., of a daughter.

MITCHELL.—On April 10th, at Cumberland-terrace, Regent's-park, the wife of Surgeon-Captain H. Mitchell, 2nd Life Guards, of a son.

SIMMONS.—On March 22nd, at Standerton, Transvaal, the wife of Herbert Charles Simmons, M.R.C.S., L.R.C.P., of a daughter.

THOMSON.—On April 9th, at Bridge House, Retford, the wife of George Thomson, M.B. Edin., of a daughter.

MARRIAGES

ALLEN—FRY.—On April 9th, at the Parish Church, Berwick-on-Tweed, William Herbert Allen, M.B. Cantab., second son of Theophilus Allen, of Stanyards, Chobham, to Elizabeth Christine Fry, elder daughter of George Fry, of Carlin Brae, Berwick-on-Tweed.

AVERILL—WRIGHT.—On April 9th, at Park-green Congregational Church, Charles Averill, M.D. Durh., Macclesfield, to Helen, youngest daughter of the late Joseph Wright, Summer hill, Macclesfield.

BOKENHAM—MAYO.—On April 8th, at the Parish Church, Cheshunt, Thomas Jessop Bokenham, M.R.C.S., L.R.C.P., of Devonshire-street, Portland place, W., to Edith, eldest daughter of the late Charles W. Mayo of Colegrove, Cheshunt, Herts.

BULLOCK—GRIFFITHS.—On April 9th, at the Parish Church, Ellesmere, Charles Penry Bullock, M.A. Oxon., M.R.C.S., L.R.C.P. Lond., of Oswestry, to Frances Elizabeth (Bessie), younger daughter of Mrs. Griffiths, Ivy House, Ellesmere.

CROWDY—SAUNDERS.—On April 8th, at St. Mary's, Bryanston-square, W., Francis Demainbray Crowdy, M.A., M.D. Oxon., of Belvedere House, Torquay, to Florence May, daughter of the late J. B. Saunders, Esq., of The Knoll, Torquay.

DOUGLAS—PEAKE.—On April 9th, at All Saints', Norwood, John J. Douglas, M.B., F.R.C.P.E., son of David Douglas, Publisher, Edinburgh, to Margaret Emmeline, younger daughter of Charles B. Peake, Woodend, Norwood.

EADY—BOYLE.—On April 11th, at Christ Church, Chelsea, George John Eady, M.D. Brux., of The Elms, Enfield, to Luna, daughter of the late Joseph Boyle, of Clapham-common.

JAMESON—STURDY.—On April 23th, at the Church of St. Mary Magdalen, St. Leonards-on-Sea, James Elliot Jameson, B.A., M.B. Dubl., of Upwell, Cambridgeshire, to Elizabeth Margaret (Madge), youngest daughter of Mr. Sturdy, of Warrior-gardens, St. Leonards.

REID—MAWER.—On April 11th, at Unity Hall, Wood Green, Arthur Lestock Reid, M.R.C.S., L.R.C.P., to Leila Ada, the eldest daughter of W. Mawer, F.G.S., of Southgate, Middlesex.

SMITH—BINDLOSS.—On April 8th, at Christ Church, Brondesbury, J. Anderson Smith, M.D. Lond., eldest son of J. R. Smith, Esq., of Hull, to Amy Helen Maud, younger daughter of the late Rev. Edward Bindloss, of Archangel.

UPHAM—NORBURY.—On April 9th, at St. George's Church, Stonehouse, Plymouth, Surgeon Charles Hazlitt Upham, R.N., son of the late Charles H. Upham, Esq., of H.M. Civil Service, to Mina Ethel Olive, eldest daughter of Inspector-General H. F. Norbury, C.B., M.D., R.N., of the Royal Naval Hospital, Plymouth.

DEATHS.

MCNICOLL.—On April 14th, at 15, Manchester-road, Southport, Edward Day McNicoll, F.R.C.S. Ed., L.R.C.P. Ed., aged 51 years, second son of the late David Hudson McNicoll, M.D. No cards.

ROPER.—On April 13th, at Arundel House, London-road, Croydon, Alfred George Roper, F.R.C.S. Eng., aged 77 years.

SHARP.—On April 10th, at Llandudno, William Sharp, M.D. Lambeth, F.R.S., of Rugby, aged 91.

N.B.—A fee of 5s. is charged for the insertion of Notices of Births, Marriages, and Deaths.

METEOROLOGICAL READINGS.

(Taken daily at 8.30 a.m. by Steward's Instruments.)

THE LANCET Office, April 16th, 1896.

Date.	Barometer reduced to Sea Level and 32° F	Direction of Wind.	Dry Bulb	Wet Bulb	Solar Radia in Vacuo	Maximum Temp. Shade	Min. Temp	Rainfall.	Remarks at 8.30 A.M.
Apr'l 10	30·22	W.	51	47	92	59	44	...	Cloudy
,, 11	29·91	WSW	49	47	92	57	43	0·03	Raining
,, 12	29·87	N.W.	48	44	92	55	42	0·04	Cloudy
,, 13	30·08	N.	45	39	96	55	38	0·09	Fine
,, 14	30·04	S.W.	43	42	57	48	41	0·03	Raining
,, 15	30·18	N.E.	45	41	95	53	41	0·12	Cloudy
,, 16	30·22	S.W.	47	45	63	49	42	...	Raining

Medical Diary for the ensuing Week.

OPERATIONS.

METROPOLITAN HOSPITALS.

MONDAY (20th).—London (2 P.M.), St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), St. George's (2 P.M., Ophthalmic 1.15 P.M.), St. Mary's (2.30 P.M.), Middlesex (1.30 P.M.), St. Mark's (2 P.M.), Chelsea (2 P.M.), Samaritan (Gynæcological, by Physicians, 2 P.M.), Soho-square (2 P.M.), Royal Orthopædic (2 P.M.), City Orthopædic (4 P.M.), Gt. Northern Central (2.30 P.M.).

TUESDAY (21st).—London (2 P.M.), St. Bartholomew's (1.30 P.M.), Guy's (1.30 P.M.), St. Thomas's (3.30 P.M.), Middlesex (1.30 P.M.), Westminster (2 P.M.), West London (2.30 P.M.), University College (2 P.M.), St. George's (1 P.M.), St. Mary's (2 P.M.), St. Mark's (2.30 P.M.), Cancer (2 P.M.).

WEDNESDAY (22nd).—St. Bartholomew's (1.30 P.M.), University Colleges (2 P.M.), Royal Free (2 P.M.), Middlesex (1.30 P.M.), Charing-cross, (3 P.M.), St. Thomas's (2 P.M.), London (2 P.M.), King's College (2 P.M.). St. Mary's (2 P.M.), National Orthopædic (10 A.M.), St. Peter's (2 P.M.), Samaritan (2.30 P.M.), Gt. Ormond-street (9.30 A.M.), Gt. Northern Central (2.30 P.M.).

THURSDAY (23rd).—St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), University College (2 P.M.), Charing-cross (3 P.M.), St. George's (1 P.M.), London (2 P.M.), King's College (2 P.M.), Middlesex (1.30 P.M.), St. Mary's (2.30 P.M.), Soho-square (2 P.M.), North-West London (2 P.M.), Chelsea (2 P.M.), Great Northern Central (Gynæcological, 2.30 P.M.).

FRIDAY (24th).—London (2 P.M.), St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), Guy's (1.30 P.M.), Middlesex (1.30 P.M.), Charing-cross (3 P.M.), St. George's (1 P.M.), King's College (2 P.M.), St. Mary's (2 P.M., Ophthalmic 10 A.M.), Cancer (2 P.M.), Chelsea (2 P.M.) Gt. Northern Central (2.30 P.M.).

SATURDAY (25th).—Royal Free (9 A.M. and 2 P.M.), Middlesex (1.30 P.M.), St. Thomas's (2 P.M.), London (2 P.M.), University College (9.15 A.M.), Charing-cross (3 P.M.), St. George's (1 P.M.), St. Mary's (10 P.M.), Cancer (2 P.M.).

At the Royal Eye Hospital (2 P.M.), the Royal London Ophthalmic (10 A.M.), the Royal Westminster Ophthalmic (1.30 P.M.), and the Central London Ophthalmic Hospitals operations are performed daily.

SOCIETIES.

MONDAY (20th).—SOCIETY OF ARTS.—8 P.M. Professor H. A. Miers: Precious Stones. (Cantor Lecture.)

TUESDAY (21st).—PATHOLOGICAL SOCIETY OF LONDON.—A Discussion on the Anatomical Results of the Radical Cure of Hernia; Specimens will be shown by the President, Mr. Golding-Bird, Mr. J. Berry, and Mr. Hutchinson, jun. Papers:—Dr. Lawrie (Weymouth): Stricture of the Sac of a Femoral Hernia.—Mr. Shattock: (1) Calculi of Calcium Oxalate from a Pancreatic Cyst; (2) Chondro-sarcoma of Humerus following Fracture. Card Specimens:—Mr. J. Clarke: (1) Multiple Embolic Aneurysms; (2) Loose Bodies from Subdeltoid Bursa.—Mr. Lunn: Aneurysm of Inferior Thyroid Artery.—Dr. Morrice (Salisbury): Deposit of Fibrin upon the Heart.—Dr. Fisher (Clifton): Thrombosis of Renal Veins in Bright's Disease.—Mr. B. Pollard: (1) Diverticulum Ilei; (2) Congenital Occlusion of Œsophagus.—Mr. Gurney (Plymouth): Metastatic Sarcoma of Both Breasts.

WEDNESDAY (22nd).—DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.—5 P.M. Dr. Abraham: Case of Lichen Ruba Acuminatus.—Dr. Eddowes: Case of Xerodermia Cured by Thyroid Feeding. And other Cases.

SOCIETY OF ARTS.—8 P.M. Mr. F. E. Ives: The Perfected Photochromoscope and its Colour Photographs.

HUNTERIAN SOCIETY (London Institution).—8.30 P.M. Discussion on Joint Affections in Nervous Diseases. Dr. Beevor, Dr. Buzzard, Dr. Ord, and Dr. A. Turner will speak.

THURSDAY (23rd).—SOCIETY OF ARTS.—8 P.M. Captain C. Rolleston: The Deserted City of Vijianagar.

FRIDAY (24th).—CLINICAL SOCIETY OF LONDON.—8.30 P.M. Clinical Evening. Mr. J. Bland Sutton: Excision of the Upper Two-thirds of the Fibula for Sarcoma.—Mr. Gordon Brodie: Deficient Development of the Lower End of Tibia after Transverse Fracture.—Mr. F. C. Wallis: Sequel to acute Swellings over the Cranium in an Infant.—Mr. R. Stanley Thomas (introduced by Mr. Pearce Gould): Deficiency in the Lower Ribs.

LECTURES, ADDRESSES, DEMONSTRATIONS, &c.

TUESDAY (21st).—ROYAL INSTITUTION.—3 P.M. Professor James Sully: Child Study and Education.

THURSDAY (23rd).—ROYAL INSTITUTION.—3 P.M. Professor Dewar: Recent Chemical Progress.

FRIDAY (24th).—CENTRAL LONDON THROAT, NOSE, AND EAR HOSPITAL.—4 P.M. Dr. Dundas Grant: The Modern Methods of Operating on the Tympanic Attic and Mastoid Process.

ROYAL INSTITUTION.—9 P.M. Professor G. V. Poore: The Circulation of Organic Matter.

SATURDAY (25th).—ROYAL INSTITUTION.—3 P.M. Professor W. B. Richmond: The Vault of the Sixtine Chapel.

Notes, Short Comments, and Answers to Correspondents.

EDITORIAL NOTICE.

IT is most important that communications relating to the Editorial business of THE LANCET should be addressed *exclusively* "TO THE EDITORS," and not in any case to any gentleman who may be supposed to be connected with the Editorial staff. It is urgently necessary that attention be given to this notice.

It is especially requested that early intelligence of local events having a medical interest, or which it is desirable to bring under the notice of the profession, may be sent direct to this Office.

Lectures, original articles, and reports should be written on one side of the paper only.

Letters, whether intended for insertion or for private information, must be authenticated by the names and addresses of their writers, not necessarily for publication.

We cannot prescribe or recommend practitioners.

Local papers containing reports or news paragraphs should be marked and addressed "To the Sub-Editor."

Letters relating to the publication, sale, and advertising departments of THE LANCET *should be addressed "To the Manager."*

We cannot undertake to return MSS. not used.

MANAGER'S NOTICES.

THE INDEX TO THE LANCET.

THE Index for the second half-yearly volume for 1895 was given in the issue of Dec. 28th. The practice of supplying loose copies has been discontinued, the Index having been placed in the centre of the journal, whence it can easily be detached, and placed either at the beginning or at the end of the volume.

VOLUMES AND CASES.

VOLUMES for the second half of the year 1895 are now ready. Bound in cloth, gilt lettered, price 18*s*.

Cases for binding the half-year's numbers are also ready. Cloth, gilt lettered, price 2*s*.; by post, 2*s*. 3*d*.

To be obtained on application to the Manager, accompanied by remittance.

MEDICAL SECRETS AND THE TRAINED NURSE.

A WRITER in *The Times* gives a facetious turn to the discussion of the interesting question of medical privilege, which in its grave aspects must be considered for the present as *sub judice*. Nothing is more satisfactory in the discussion than the general recognition of the reticence of the great profession which gets deeper insight into human nature than any other. The letter we refer to must not be taken too literally, but in its way it is a striking illustration of this point, and suggests the sad consequences of extending to nurses the severe silence which is imposed on medical men. The writer must be of the female sex from the feeling way in which she expresses the dread and the dulness with which she anticipates such an extension of ethics. The freer tongue of the "trained nurse" gives animation to the sick room, which even extends to the whole village or neighbourhood of her operations, "till some busybody in high life awakens to the fact that she is the bee that carries the pollen of unrighteous gossip from door to door." The writer surely does not mean to imply that "training" *per se* adds to the vice of lingual incontinence. The old nurse in that respect at least might fairly be matched with the modern. But we may make this admission: that if a few of the lessons in transcendental therapeutics &c. were exchanged in the training of our modern nurses for a few lessons in common sense and the management of patients and of their friends great advantage would accrue all round. And amongst the earliest of such lessons would be the reverence due to the privacy of human nature in its weakest forms and states.

S. C. R. M.—Our correspondent's suggestive remarks will receive our attention. Nothing would be gained by the publication of his letter.

Doubtful has omitted to enclose with his communication his name and full address.

"THE POISON OF THE PRIMULA."

To the Editors of THE LANCET.

SIRS,—The following case, at present under my care, will no doubt be interesting as bearing upon your paragraph on the primula obconica in THE LANCET of March 28th.

On Feb. 28th last I was consulted by two nuns, one of whom complained of itching on the wrists, hands, and cheeks, and also of chronic dyspepsia. I gave an ointment and a stomach mixture containing bichromate of potash, thinking that the skin troubles were dependent on the stomach affection. On March 9th the nuns returned with the same symptoms, there being nothing to see except diffuse redness of the hands. On March 14th they came again, saying the itching got worse. Being summoned on the 17th I was surprised to find the back of the hands, especially the left one, the wrists, and cheeks intensely swollen, and the right eyelids œdematous, along with intolerable itching, which effectually warded off sleep and rest. The parts were of a dusky hue and the temperature registered 103° F. I was doubtful as to its being true erysipelas on account of the hue and so I enquired carefully as to where she had been and what she did. I was told that it was her duty to attend to the plants in the glass-houses of the convent. This called up in my mind what I had read in the "Medical Annual" about a year ago concerning a dermatitis occurring in gardeners from handling primulas, and I at once concluded that this was just such another case, especially after being assured that they had a great number of these plants. I painted the affected parts with ichthyol, which soon stopped the itching, and in about a week every trace had disappeared (during which time she kept her bed); but last Monday she came to me complaining of itching on the back of the left fingers, where I found several vesicles. The paint was reapplied and with the same excellent results.

I am, Sirs, yours truly,

Victoria-villas, York, March 31st, 1896. P. W. SCHMIDT, M.B. Edin.

To the Editors of THE LANCET.

SIRS,—Last autumn a man came to my surgery suffering from a severe inflammatory eczema extending from the fingers to the elbows; both sides of the cheeks and neck were in the same condition. On questioning him I found that he was a gardener and had worked in the same situation for eighteen years, and for the last few days had been busy among some primula obconica, working with the shirt sleeves rolled up. The inflammatory condition on the neck and face had evidently been caused by rubbing those parts with the hands. I prescribed a lead lotion for him and he recovered in a few days. I also advised him not to touch the plants again with the naked hands, which advice he has followed and he has remained quite free from the complaint.

I am, Sirs, yours truly,

Bradford, April 7th, 1896. A. GRAY, M.B. Glasg.

Anxious.—The case supposed is not one which would necessarily come before the General Medical Council. A resident unqualified assistant is not so likely to bring his principal into a violation of the rules indicated by the Council as one resident outside. But apart from this aspect of our correspondent's plans he will forgive us for saying that they seem to us open to objection in an ethical respect. He does not say whether the former principal of his relative and unqualified assistant has sold his practice. But if so it is clearly not right for our correspondent to take an unqualified assistant whose popularity with the patients of his former employer might be used to draw patients from the practice. We submit to him that he should reconsider this arrangement apart from any fear of the action of the General Medical Council.

A SKIN AFFECTION PRODUCED BY WORKING IN TEAK.

To the Editors of THE LANCET.

SIRS,—I shall be obliged if you or any of your readers can inform me whether carpenters working in teak occasionally suffer from a skin affection very similar to that described as resulting from handling primula obconica and affecting the face and arms.—I am, Sirs, yours truly,

April 12th, 1896. H. N. A.

IMPURE TARTARIC ACID.

AT Devizes, on March 19th, the manager of a tea company's stores was summoned for selling a quantity of tartaric acid on Feb. 14th which was not of the nature and substance demanded. The analyst for Wiltshire stated that the sample contained 45 per cent. of pure tartaric acid, 51 per cent. being a compound of a crude acid, and there was a residue of 3 per cent.; he added that the sample, although very impure, was not injurious to health except in certain cases where it might be used medicinally and fail in the purpose intended. For the defence it was contended that the company had received a warranty from the wholesale firm supplying the acid that it was "of good mercantile quality and guaranteed genuine English make." The Bench said that the defence had failed both with facts and the law, and the defendant was fined £3 13*s.* 6*d.*

N. Y. Z.—Our correspondent is at liberty to undertake other work and would not thereby forfeit his diplomas. The profession, however, is a jealous mistress—once desert her and it will be difficult to reclaim her.

A QUESTION OF ETHICS.

To the Editors of THE LANCET.

SIRS,—I shall be obliged if you will advise me how to act towards a professional brother under the following circumstances. During the last few months I have been attending a very old lady who suffered merely from the usual infirmities of old age. I used to call to see her probably about once a fortnight. I heard to-day from her daughter (who called to pay my fees) that she died a week ago, and that on the day of her death a medical man, who happened to be passing the house, was called in and found her dying, and told them to send down to his house for a certificate of death, for which they paid one shilling. The daughter told me that the medical man was told that I was in attendance and he said he would communicate with me. I have not heard from him, though I have seen him and exchanged greetings with him almost daily since.

I am, Sirs, yours truly,

March 30th, 1896. F. L. HALLUCIS.

*** The facts are very remarkable as detailed by our correspondent, who, of course, was the right person to have filled up the certificate. We can offer no explanation of the conduct of the practitioner who was called in. The kindest thing our correspondent can do is to see him and discuss with him the ethics of the situation, of which he seems to have singular views. We should be pleased to receive any information that places his conduct in a different light, and it is always well to remember that the friends of patients sometimes err in their account of what has happened.—ED. L.

Mr. W. O. Hanlan is thanked for his communication (enclosing a copy of his letter to the Medico-Chirurgical Society of Glasgow) and his eloquent little hymn. The process alluded to is physiological, not pathological, and the main conclusion of the writer is untenable, we think; but that it would be desirable that more persons understood the hygiene of domesticity before marriage is undeniable, as it is undeniable that a widespread ignorance on such topics has led to the loss of life of many infants.

"ADVERTISING DENTISTS."

To the Editors of THE LANCET.

SIRS,—I have noticed your remarks anent the above, also Mr. Jones's reply, in which he states the Royal College of Surgeons in Ireland is quite capable of looking after itself. This statement I deny, and I state further that the said College shamefully neglects the dignity of its Licentiates in Dental Surgery. Let me here state a case. A friend of mine wrote not very long ago to the College informing it that one of its Licentiates was advertising broadcast a so-called American dentists' association, and had in a prosecution case admitted he was the proprietor, although the name of a non-licentiate only appeared as manager on the various bills and books. The reply my friend received from the College after a lapse of time was to the effect that the individual had promised not to repeat such conduct. Nevertheless, from that day to this pamphlets, books, and advertisements of the association still continue to be sent out broadcast, and the offender still defies the Royal College of Surgeons in Ireland.

I am, Sirs, yours faithfully,

April 13th, 1896. FAIRPLAY.

Enquirer.—We have already dealt with the publication which our correspondent forwards us. The coupon is, of course, the most objectionable feature.

Leytonstone is thanked for his communication. We have noticed the report in a leading article.

COMMUNICATIONS not noticed in our present issue will receive attention in our next.

During the week marked copies of the following newspapers have been received:—*Somerset County Herald, Keighley News, Alnwick Gazette, Doncaster Chronicle, Carlisle Journal, Manchester Courier, Oban Times, Hereford Times, Whitby Gazette, Wakefield Free Press, South Wales Daily News, Cleckheaton Guardian, East Anglian Daily Times, Derby Standard, Chester Courant, Glasgow Herald, Derry Standard, Bradford Observer, Dundee Courier, Halifax Guardian, Bridgwater Independent, Sussex Daily News, Barnsley Independent, Newcastle Leader, Wolverhampton Chronicle, Bristol Times, Sheffield Independent, Alcester Chronicle, Birmingham Post, Freeman's Journal, Huddersfield Chronicle, Western Morning News, Leicester Post, Eastern Evening News, West London Observer, Times of India, Pioneer Mail, Builder, Yorkshire Post, Edinburgh Evening Dispatch, Bristol Mercury, Architect, Scotsman, Liverpool Daily Post, Sanitary Record, Leeds Mercury, City Press, Mining Journal, Local Government Chronicle, Weekly Free Press and Aberdeen Herald, West Middlesex Standard, Reading Mercury, Boston Independent, Hertfordshire Mercury, Surrey Advertiser, Gloucestershire Chronicle, Local Government Journal, Western Mail, Le Courrier de la Presse, Daily Free Press (Aberdeen), Leicester Daily Mercury, Newcastle Daily Journal, Evening News (Portsmouth), Bolton Evening News, Citizen, Shields Daily News, Citizen (Gloucestershire), Cromer Post, Rossendale Free Press, &c., &c.*

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X.—X., Leeds.

Y.—Yorkshire College, Leeds, Sec. of.

Letters, each with enclosure, are also acknowledged from—

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